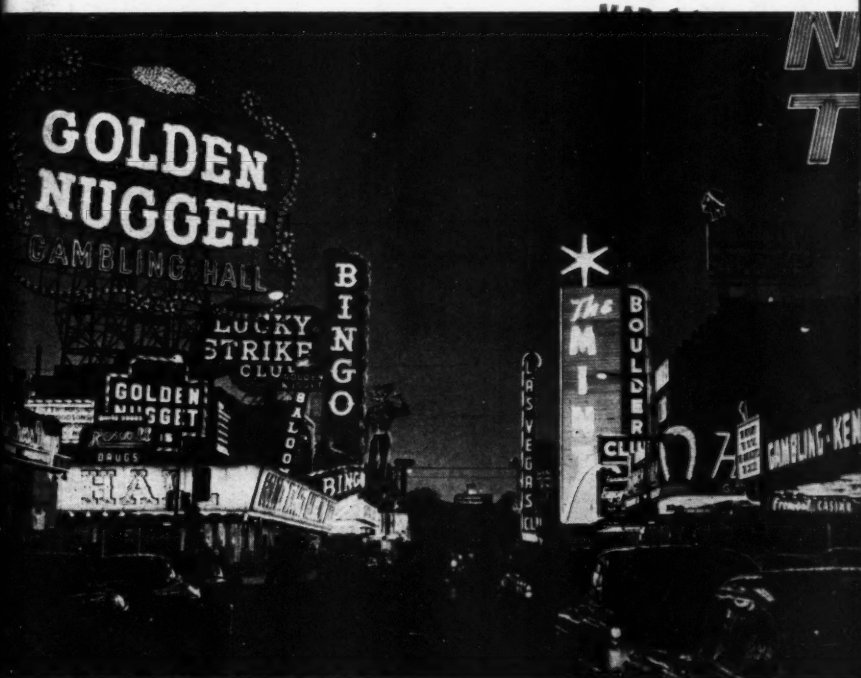


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Oral Hygiene

AA

MARCH 1959 THE JOHN GREER LIBRARY

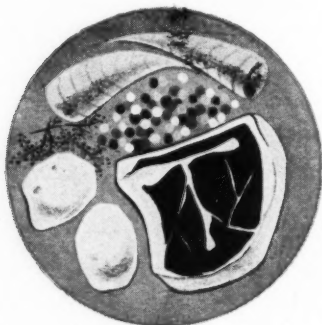


The Nevada State Dental Convention will be held in Las Vegas, from May 10 to 12.

In this issue:
ARE DENTISTS PAID ENOUGH?



BECAUSE ORAL HEALTH



BEGINS WITH NUTRITION...



GEVRAAL CAPSULES

Vitamin-Mineral Supplement Lederle

14 vitamins — 11 minerals . . . broad supplement to offset nutritional deficiencies often first manifest in dental disorders and, thus, frequently subject to first diagnosis by the dentist. Economical, completely acceptable, once-a-day dosage, oil-free, powder-filled.

In attractive Jubilee Jar of 100, and bottles of 30 and 250.

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Pearl River, New York



SUPERIOR
TO ASPIRIN OR
BUFFERED
ASPIRIN...

IN THE MANAGEMENT OF DENTAL PAIN

The widespread
acceptance of Anacin Tablets
by the profession is overwhelming
evidence of their safety and effectiveness.

The rationale may be simply explained:

Anacin is superior to aspirin or buffered aspirin.

Medical literature substantiates that a *combination* of ingredients is better tolerated, is more effective and smoother in action than equivalent doses of any one used individually.^{1,2,3} Anacin is such a formulation.

One ingredient in particular (acetophenetidin) exerts more selective sedative action and is efficacious in diminishing apprehension and tension as well as affording rapid and prolonged analgesia.⁴ Excellent tolerance. Preferred by more dentists than any other analgesia.

Always

ANACIN®

FOR A BETTER TOTAL EFFECT

WHITEHALL LABORATORIES,

NEW YORK, N. Y.

References: 1. Goodman, Louis S. and Gilman, Alfred: *The Pharmacological Basis of Therapeutics*, sec. ed. 1955. 2. Krantz and Carr: *Pharmacologic Principles of Medical Practice*, 1954. 3. Hammes, E. M., Jr.: *Pain-Relieving Drugs*, J. Lancet, 79:67, Feb. 1952. 4. Wolff, Harold G.: *Headache and Other Pain*, Ox. University Press, 1948.

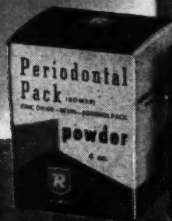
Rower top performers...

AIDS TO
BETTER
DENTISTRY



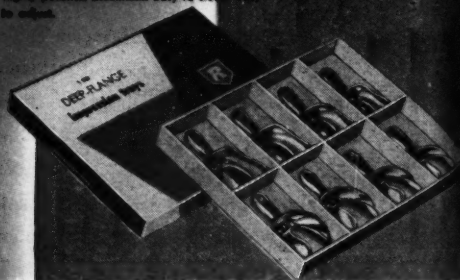
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For positive, postoperative protection of surgically treated tissue.



DEEP-FLANGE IMPRESSION TRAYS

Permit easier, quicker and more complete impressions. No tissue distortion. Made of highly polished aluminum. Easy to clean and to adjust.



ROWER DENTAL MFG. CORP. Boston 16, Mass., U.S.A.

Please send me the following items
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		QUANTITY	
PULPDENT	{ Liquid (15 cc.)	_____	\$2.50 ea.
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PERIODONTAL PACK Combinations	{ 4 oz. Powder	_____	
	{ 1 oz. Liquid	_____	3.25 comb.
	{ 16 oz. Powder	_____	
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AMALGAM CARRIER	{ Single (reg.)	_____	4.75 ea.
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SOF-TI SALIVA EJECTOR	{ (child)	_____	2.50 ea.
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Brand of CALCIUM HYDROXIDE SUSPENSION

Protective cavity liner. For use directly under any filling material including silicate cements and cements also under inlays, crowns and bridges.



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Lightweight, stainless steel construction. Perfectly balanced, easy to clean.

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Light weight and sturdy construction. Applied to most comfortably in mouth. Available in adult and children's sizes. Comes complete with tips.

SOF-TI TIPS for SOF-TI SALIVA EJECTOR

Made from soft, pure gum rubber. Perforations do not clog and are spaced to eliminate "sucking up" or "firing" of tissue.

FILL OUT COUPON

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MAIL TODAY!

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Boston 16, Mass.



The Publisher's CORNER



By Mass

No. 452

A Reader Remembers

THE PIECE about "Letter Men" in December ORAL HYGIENE caught the eye of an old friend of whose friendship the CORNER had not previously been aware. Doctor Richard P. Strahl of 1025 Medical Dental Building in Portland, Oregon, was writing his first letter to the magazine. "Dear Mass," he wrote, "For I know you far better by your nickname than by your given name." Then there followed quotes from old, old CORNERS, copied by Dick Strahl "from issues that must have appeared at the beginning of the Continental conflagration, World War II." Here in the current CORNER there's room only for what you might call quotes, for example:

"You can't help marveling at British calm. A little calm now and then might be good medicine for us Americans. Our tendency is to make a big, beetle-browed problem out of a good many things that don't really matter." And another quote:

"Last month in Chicago, in hotel lobbies and bedrooms, I heard various phases of the dental business discussed by men who seemed to believe that the very stars and planets in the firmament will come crashing down if this thing happens or that thing doesn't happen in our quaint little field. Last week at the New York Greater Dentistry Meeting, I heard the tense voices of dentists vibrating to the same tune. There are men willing almost to die for a so-called scientific theory, or for a technique, or for a magazine. I am not—not any more. You are looking at my favorite periodical, my favorite among all the world's journals, my dear little ORAL HYGIENE. But with only one life to give, and not a great deal of that left, I do not intend to give it to this superb little book."

And Dick Strahl kept on quoting: "There was a time, before I became old, and mellow, and calm, when bright and early each morning I presented myself as a human sacrifice upon the altar of this paper. It is one thing to go to work in the morning, it is something quite a little different to go to work all aquiver to bleed and die for

What do you want in a dental unit?

Dentalair has everything!

The new Dentalair Unit has all the features necessary for modern dentistry—yet performs every operative procedure in strict classical manner! No new techniques to learn—there's no need for "stroking" or "brushing," since both torque and speed are controlled by a touch of the finger. Dentalair provides full, normal tactile perception at all times, especially important when visibility is limited.

And talk about patient comfort! Unsolicited quotes from patients—"completely at ease"... "better than the regular drill" ... "did you do anything?"—testify to their complete acceptance of this new unit. Check the features described here, and then try Dentalair for yourself, at your next convention. Or, write for the name of your nearest dealer, who will arrange a demonstration. Address: Dept. OH-15



TWO HANDPIECES

Dentalair comes complete with contra-angle and straight handpieces; eliminates time-consuming changeovers. (Single handpiece unit optional.)

VARIABLE SPEED—at your fingertips!

Fingertip control varies speed quickly and without the need for awkward floor rheostats.

HIGH OPERATING SPEEDS

The high speed Dentalair handpiece (0 to 175,000 turbine rpm) does more work in an eight-hour day than any other unit.

AIR TURBINE

Precision-made by Atlas Copco, world's largest manufacturer of pneumatic equipment.

TROUBLE-FREE SERVICE

... thanks to precision design of every part. Example: After nine months' continuous use, a contra-angle handpiece required replacement of just one \$8.00 part.

AUTOMATIC SPRAY

Fully-adjustable air-water mixture ... can be shut off completely.

ACCEPTS STANDARD SHANK BURS, ETC.

Protects investment in present burs, discs, steels, stones, diamonds, and carbides.

SERVICE INSURED

A five-year insurance policy with the world's largest and oldest insurance organization guarantees spare part availability.

Dentalair

610 Industrial Avenue
Paramus, New Jersey

Atlas Copco

930 Brittan Avenue
San Carlos, California

National Representative: Parkell Company, 23-06 31 Avenue, Long Island City 6, N.Y.


the job, whether the job is the magazine business or dentistry."

Dick's quoting continued: "For years, I was the self-appointed human sacrifice on ORAL HYGIENE's altar. The bleeding and dying were mental, of course, but that's the worst kind. Worry, as a rule, is worse than the thing worried about, even if it happens, which it generally doesn't. Strangely enough, it was the Depression that fumigated my mind. What really happened I guess was that I broke my worrier in 1932 when we started the new *Dental Digest* just about 15 minutes before almost everyone stopped advertising. Worries became so numerous that it was necessary to list them lest any be overlooked. One day I realized that although I was worrying

as fast as possible, I was still way behind.

"Worrying about that, I began to think that maybe the added strain would kill me. Then it somehow occurred to me to think the thing through. Suppose that worry did kill me. Suppose my family or some friend arranged with the tombstone people to carve the real truth on my stone. What would the real truth be? At that point, in my mind's eye, I could see the tasty design, see the lettering itself: MERWIN MASSOL. HE DIED BECAUSE OF WORRY ABOUT DENTAL ALMANACS. R.I.P.

"Everybody, I decided, who happened by and read the inscription would laugh like hell. And, after all, you can't have people laughing at your tombstone."



(KT) TIME SAVERS

To Make Your Young Patient

- Cooperative
- Friendly
- Ask for More Appointments.

GOLD, SILVER and COPPER PLATED.

Approx. $\frac{3}{8}$ Actual Size

Awards

"WORK LIKE A CHARM"

Awards are so inexpensive and save valuable chair time. Carefully designed in good taste — not to offend parents or schools.

FOR THE BEST — SPECIFY K-T AWARDS

At Your Regular Dealer.

KUMFORT-TYME CO. P. O. BOX 247 • LOMITA • CALIFORNIA

**BUY
SECURITY BONDS**

93.3% Effective in Gingival Bleeding

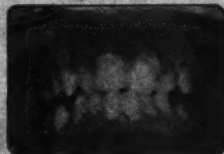
AMOSAN produced improvement in the treatment of gingival inflammation.

AMOSAN (Sodium Peroxyborate Monohydrated buffered with Sodium Bitartrate Anhydrous) used as a mouth rinse, is a 93.3% effective ancillary agent in the treatment of inflamed bleeding gums. A rigidly controlled triple-blind study at a leading medical center¹ produced those convincing results.

A typical case history:

Sex: Male **Age:** 18

Diagnosis: Acute Vincent's Infection



FIRST VISIT

Treatment: Regular Amosan rinse.



2 DAYS LATER

Results: After 2 days, all acute symptoms, pain, swelling, tenderness and infection, were gone.

AMOSAN is a concentrated oxygenating agent that combats anaerobic oral bacteria without the hazards and expense of antibiotics. It also has detergent and hemostatic actions, yet is gentle and non-irritating with an almost neutral pH (approx. 8).² Low surface tension (37.3 dynes per cm.) of AMOSAN solution promotes pocket penetration.

At the first sign of bleeding gums, gingival recession or tooth mobility, use, recommend and prescribe AMOSAN.

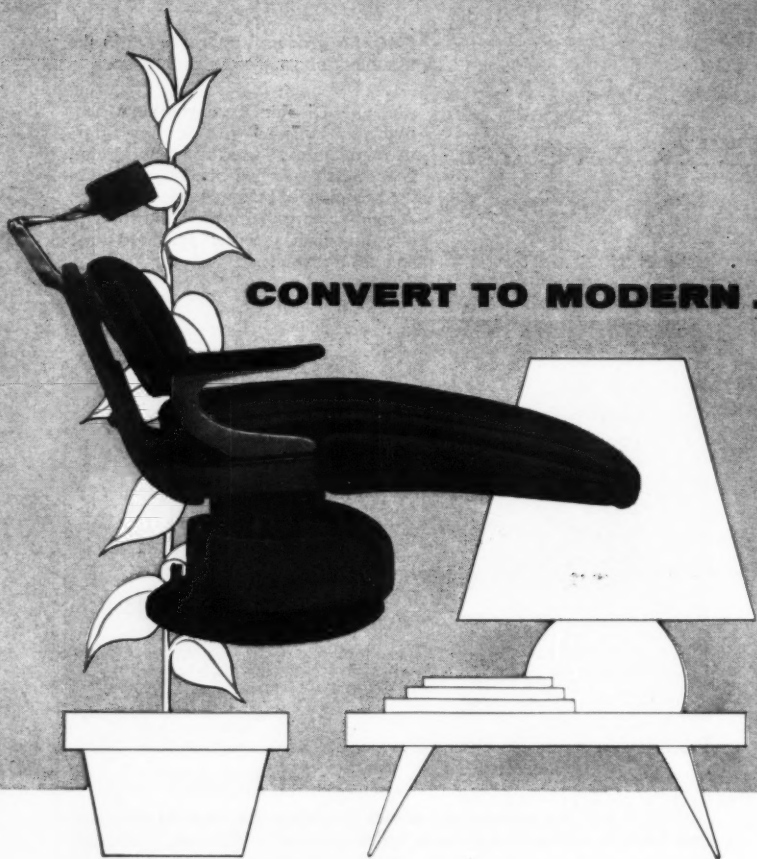
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THE KNOX COMPANY 1400 Cahuenga Blvd., Los Angeles 28, Calif. / Fort Erie, Ont., Canada

1. *The New York Hospital—Cornell Medical Center, Presented as a Scientific Exhibit at the American Dental Association Annual Session, November 1957.*

2. *Behrman, S. J.; Fater, S. G.; Grodberg, D. L.; An Evaluation of Oxygenating Agents in the Treatment of Gingival Inflammation. J. Dent. Med., Oct. 1958.*



CONVERT TO MODERN ...

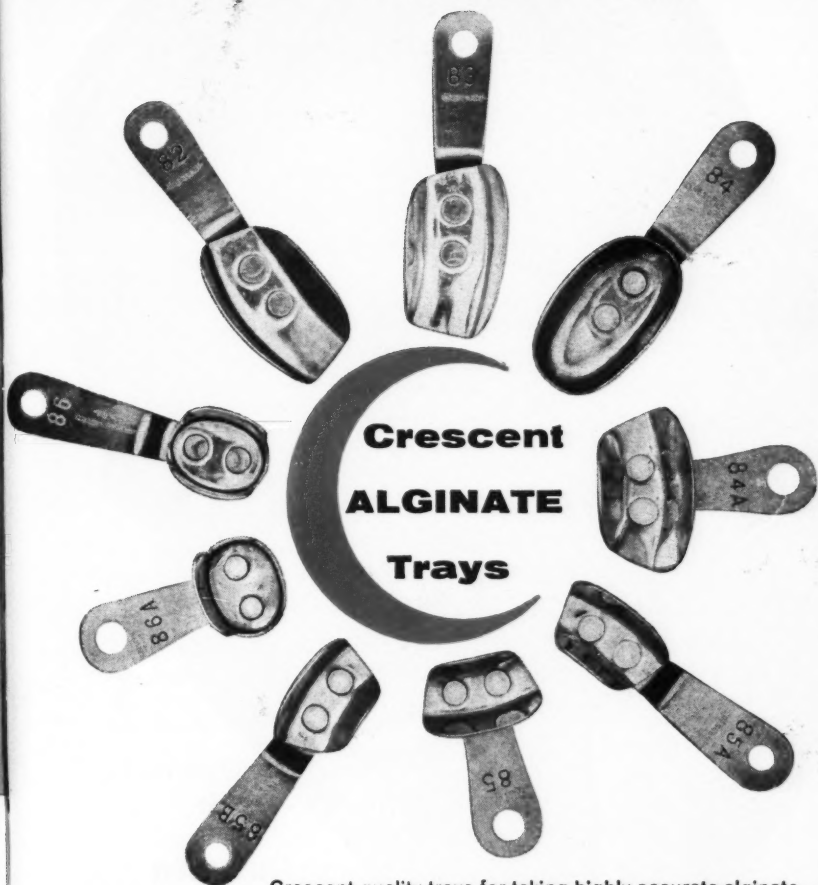
... FOR ALL PHASES OF DENTISTRY

through the addition of a Hek Seat, Back Rest and Head Rest on a conventional dental chair. The result—a modern yet professional looking chair affording the ultimate in patient comfort. Subtle, soothing vibrator optional.

An ever-increasing number of dentists throughout the U. S. and Canada are endorsing this significant advancement.

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Crescent quality trays for taking highly accurate alginate impressions for bridgework of every type and technic **are now available in convenient sets of nine.** Designed to satisfy every requirement these trays are carefully made of heavy gauge aluminum, and highly burnished for easy removal. The complete assortment, illustrated above, only \$4.05 through your dealer.

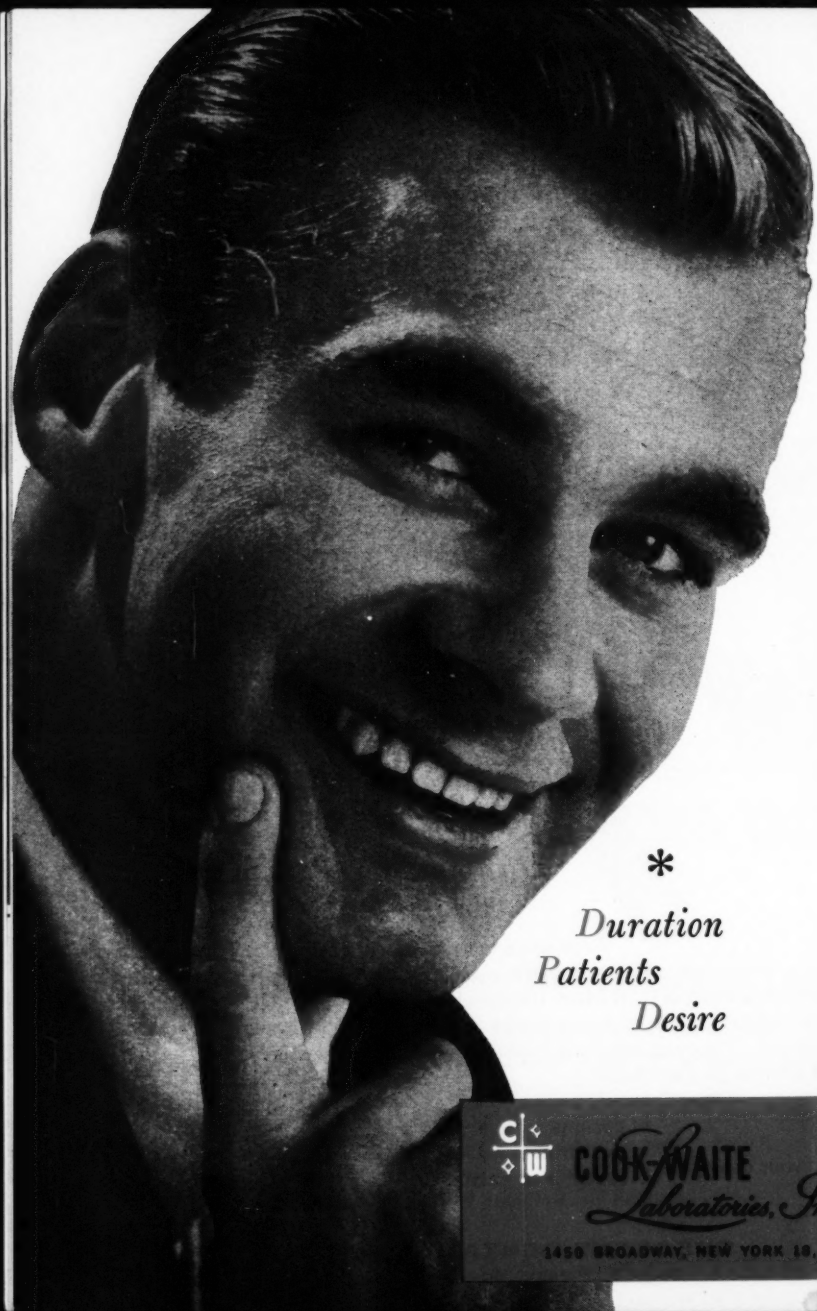
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Patients
Desire*



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XUM

*High Rotary Speeds Demand
the Anesthetic with . . .*

DPD*

Yes . . . patients *do* desire a duration of anesthesia that keeps them comfortable while you do your unhurried, meticulous job . . . but then doesn't linger unnecessarily long after you've dismissed them.

In fact, isn't that *precisely* the type of duration you, too, desire? Not so short that you have an agitated patient requiring reinjection . . . not so long that you have a patient disgruntled by protracted paraesthesia.

That's the duration you get with RAVOCAINE HCl 0.4% and NOVOCAIN 2% with NEO-COBEFRIN 1:20,000 and, of course, you also get these other fine features for which this solution is acclaimed:

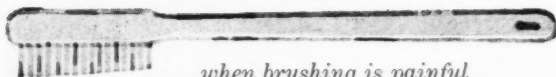
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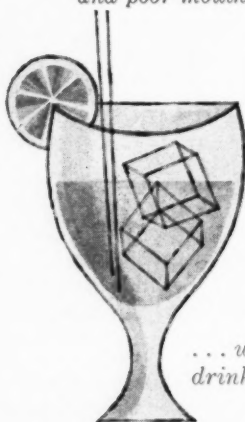
RAVOCAINE[®] HCl AND NOVOCAIN[®]
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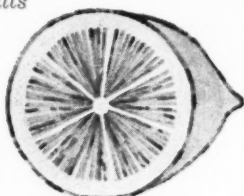
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... when brushing is painful
and poor mouth hygiene results



... when hot or cold food and
drink cannot be tolerated



... when acid fruits
are not fully enjoyed



... when your explorer's lightest touch cannot be endured

put your
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Thermodent^{T.M.} **Tooth Paste ... for hypersensitive teeth**

The most recent report¹ on Thermodent, in which 74 patients were studied, states that 77% realized moderate to complete relief of hypersensitivity. In increasing numbers, patients who formerly could be treated only occasionally now enjoy *continuous* relief through routine brushing with this "at-home" adjunct to office therapy. Not only can they tolerate hot and cold food and drink in comfort, but daily brushing without pain is once again possible. Regular use of Thermodent also helps to overcome the discomfort of dental instrumentation.

Promoted only to the dental profession, Thermodent is available in 2-oz. tubes at all pharmacies.

1. Abel, I.: Oral Surg. 11:491, (May) 1958.

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PREFERRED IN 49 STATES

... for faster amalgam work

Dentists like Micro's ease of use Pre-loaded in special capsules, pellets of Micro and Micro Non-Zinc Alloy are ready for instant amalgamation at the chair.

Dentists like Micro's working properties Smooth mix. Plump, fat amalgam that's buttery slick without graininess. Dense, cohesive structure . . . not springy. Fast initial set for instant carving. Rapid development of strength.

MICRO ALLOY PELLETS

*Doctor, we've used
Micro Pellets for almost 3 years now!*

*How did we get along
without them?*



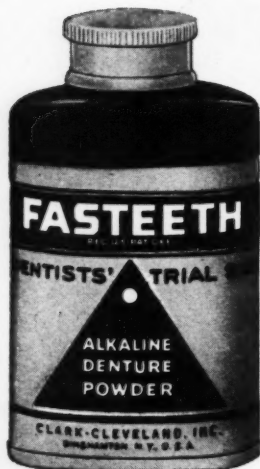
For modern materials

CAULK

Milford, Delaware



- 1** Chewing efficiency of natural teeth can be measured clinically in terms of the number of chews necessary to reduce food to a specific degree of fineness. The efficiency of dentures can be measured in the same manner.

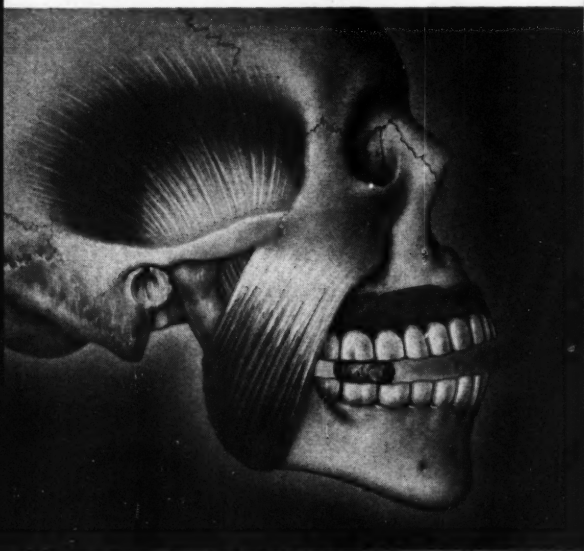
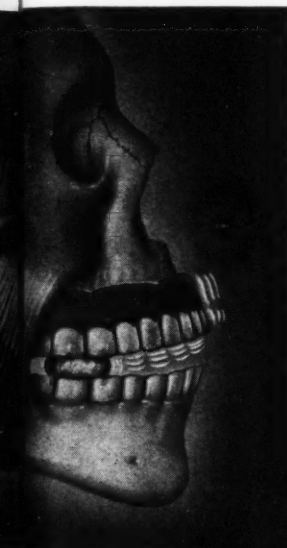


- 2** With normal efficiency rated at par 100, the average efficiency among one hundred denture wearers dropped to 26. This loss was due partly to the discomfort and shock of chewing and partly to denture instability.

FASTEETH is the alkaline fixative powder that is made exclusively by Clark-Cleveland, Inc., Binghamton, N. Y.

Eating Efficiency with Dentures Raised Immediately

At least 74% of the normal chewing efficiency of natural teeth is lost in the average denture. Now, a special powder helps restore it.



- 3** **Average eating efficiency** rose sharply to 35 when FASTEETH fixative powder was sprinkled on dentures. FASTEETH forms a cushion between plates and sensitive gums relieving irritation and distributing shock. It also stabilizes dentures and makes it easier to eat the essential foods such as meats and fruits. It adds immeasurably to the attitude of the patient.

THE TRANQUILIZER UNIQUE IN DENTAL PRACTICE

calms
apprehensive
patients

protects
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schedule



Lost time due to chair fear or "drill consciousness" is minimized. On ATARAX, calming effect was noted in 71% (30 out of 42) of tense, anxious patients given therapeutic dosages 10 to 15 minutes before treatment.¹

In lengthy procedures: "All of 150 patients remained fully conscious and ambulatory on ATARAX after oral surgery, including many prolonged operations."² Reaction to external stimuli was unaffected, even though fear and apprehension were completely insulated.

plus . . . **RAPID ACTION** - ATARAX generally takes effect within 15 minutes. **SAFETY** - Virtual absence of side effects, safe even in children. **FLEXIBILITY** - Tablets and syrup.

ATARAX®

(brand of hydroxyzine)

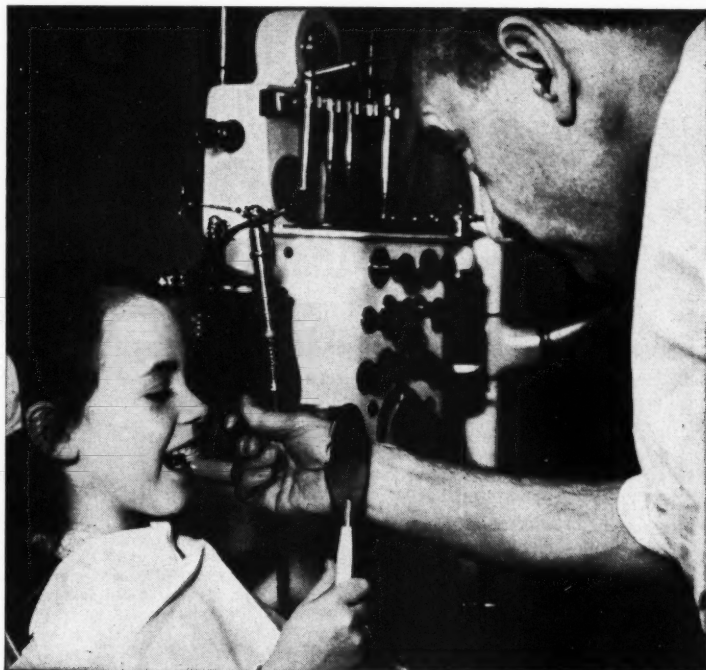


New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

References: 1. Grauer, D. E.: Dent. Survey
34:1025 (Aug.) 1958. 2. Abramson, A. S.: J.
South. California Dent. A., in press.

Dosage: Adults. Good-tasting syrup, 1 tablespoon, or one 25 mg. tablet. Or you can prescribe 5 or 10 tablets for the patient to take at home. Children, 1 or 2 10 mg. tablets or 1 to 2 tsp. syrup. Suggest dosage be taken approximately 1 hour before each visit.

Supplied: Syrup, in pint bottles; tiny 10 mg. (orange) and 25 mg. (green) tablets, bottles of 100.



Oral Hygiene

the first step in caries control

Dentists agree that they can help prevent caries better if they first obtain their patients' cooperation in good oral hygiene. Because new Ipana® is so effective in its detergent action and is pleasant-tasting for breath-refreshing benefits too, patients are encouraged to develop good oral hygiene habits. They are more likely to realize the importance of proper brushing and regular dental checkups.



ANOTHER FINE PRODUCT OF BRISTOL-MYERS

New Ipana with WD-9 (sodium lauryl sulfate)... is twice as effective against decay bacteria as any other leading tooth paste. Ipana thoroughly cleans the entire mouth, to help prevent bad breath, and has a pleasant taste and refreshing after-taste.

Bristol-Myers Company, 19 West 50 Street, New York 20, N. Y.

*A unique
opportunity...*

Own a high profit business that runs itself

OPEN A PHILCO-BENDIX SELF-SERVICE LAUNDRY STORE!

Today, many doctors, lawyers and professional men of all kinds are going into the self-service, coin-operated laundry business. The reasons are obvious. Many of these new-type laundry stores are delivering a 25% return on a small capital investment.

Here are some of the facts: The coin-operated laundry is one of the fastest growing businesses in the country. Customers simply come into the store, wash and dry their clothes in metered machines and leave.

Minimum supervision required: A Philco-Bendix coin-operated laundry needs no attendant. Only a couple of hours a week is required to empty the coin boxes and supervise efficient operation. There are no credit problems—strictly a cash business. Machine repair and daily maintenance are contracted to local people. You can spend full time with your regular business or practice and let the coin store run itself.

Why are they so successful? Coin-oper-

ated laundry stores offer customers up to a 65% saving over attended-type wash and dry service. They are convenient for busy people because they remain open 24 hours a day, seven days a week. They give customers a chance to do their own washing—their own way.

Small initial investment: The overall cost of opening one of these stores, equipped with Philco-Bendix Commercial Washers, *the only complete line of commercial washers engineered for coin use*, is surprisingly low. Only a small initial investment is required. The balance may be financed through Philco Finance Corporation. Return is so rapid that many investors amortize the total cost within a year.

Act now! Investigate this exciting new business opportunity today! Send the coupon below for full information. Complete data on business locations in your area and valuable help in all phases of planning, financing and promoting a coin-operated laundry store are available from local distributors.

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Please send me information on Philco-Bendix Commercial Washers... also the name of my local distributor.

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COMMERCIAL LAUNDRY SALES

DO YOU KNOW?

More and more dentists are prescribing fixed bridge-work for their patients. This trend to permanency in prosthetics has been considerable within the last few years and continues unabated. The results are better aesthetics, greater functional perfection, avoidance of adjustments, complete satisfaction. The restoration becomes a part of the wearer.

Spyco #6 is increasingly preferred by many for its assurance of ALL of the physical properties and aesthetic qualities requisite not only for fixed bridges, but also for hard inlays, $\frac{3}{4}$ crowns and abutments subject to maximum stress. It has outstanding strength and hardness to defy the severest stresses, to resist marginal distortion and warpage under the most trying circumstances. Spyco #6 has a beautiful, light coin color. It complies with A.D.A. Specifications #5, Type C Inlay Golds. Only \$2.15 per dwt. at your dealer's.

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NOW! Throw-Away

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SOAP CARTRIDGE

Exclusive with

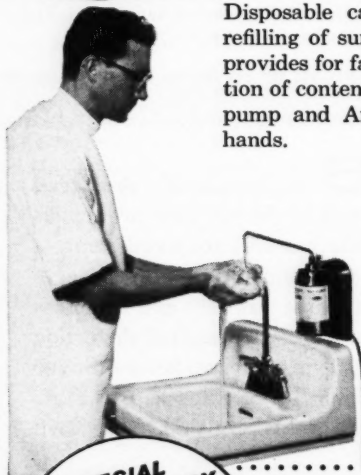
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Foot-operated
**SOAP DISPENSER
SYSTEM**

Disposable cartridge puts an end to messy refilling of surgical liquid soap containers and provides for fast replacement with no adulteration of contents. A touch of the Ped-O-Flo foot pump and Anasep soap is instantly in your hands.

ANASEP IS KIND TO YOUR HANDS

Fortified to surgical scrub standards with G-11*, Hexachlorophene. Continuous use of Anasep leaves a bacterial mantle of protection on the skin after rinsing. The low pH aids in keeping hands soft and smooth even after repeated washings. *TRADEMARK OF SINDAR CORP.



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**SPECIAL
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\$13⁵⁰
only
for dispenser and
6 months' supply
of soap

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Please send me one PED-O-FLO dispenser and case of 8 ANASEP cartridges—a \$20.50 value, now only \$13.50.


Name

Address

City Zone State

BILL ME ☐

MY CHECK ENCLOSED ☐



Extracted molar with gross stain, calculus, cervical erosion, caries



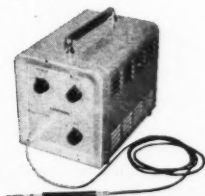
The same tooth after cleaning with the Portable Prophylaxis Unit

RAPID METHOD FOR PROPHYLAXIS AND CALCULUS REMOVAL

- Complete prophylaxis and deep scaling is now routinely done in one sitting by users of the Cavitron "30" Portable Prophylaxis Unit, with a saving of up to 50% in chair time.

Effortless

Instead of fatiguing hand instrumentation, the operator merely *guides* the lightweight handpiece along the tooth, quickly dislodging subgingival and supragingival calculus. Stubborn surface stain, so resistant to conventional procedures, is also easily removed. Crown and root surfaces are left velvety smooth.



The Unit is fully portable, can be installed in minutes. Supplied with basic set of prophylaxis tips; tips for amalgam condensation, gingivectomy and root canal therapy also available

Clear Field

A continuous water spray washes away debris, maintaining a clean, clear field. *No abrasive is used.* Vision is good; ready access to all areas is provided by quick-snap-in tips available for use with the Unit.

Gentle

Patients report that the procedure is extremely gentle, with complete absence of unpleasant scaling sensation. Tissue laceration, bleeding and postoperative sensitivity are virtually eliminated.

Private Demonstration

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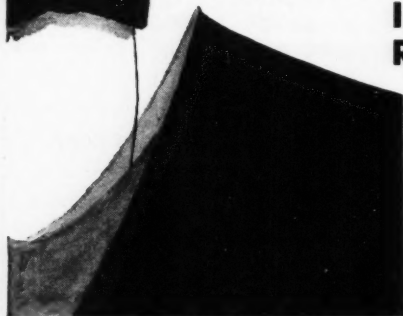
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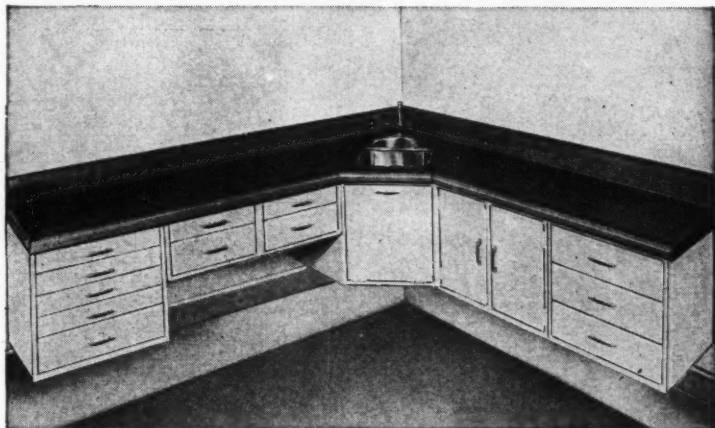
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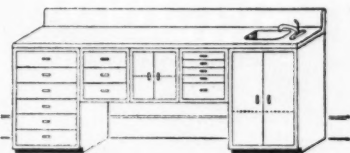
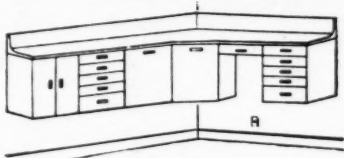
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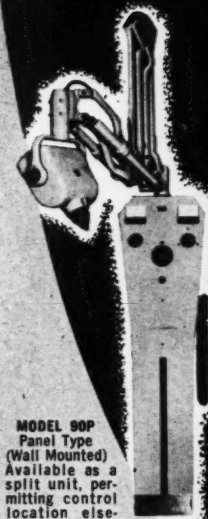
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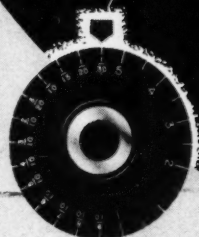


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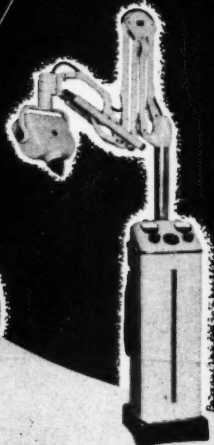
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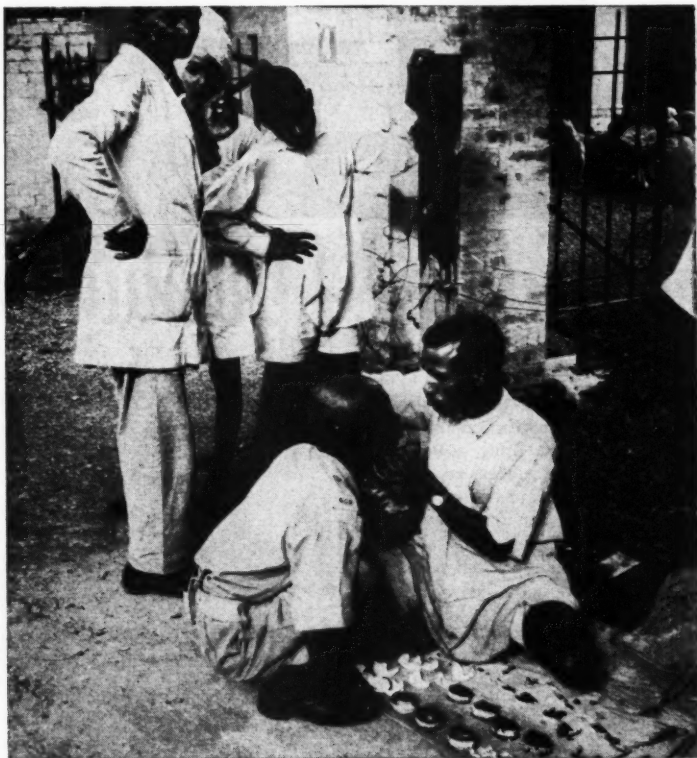
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Picture of the Month



DOCTOR Bert W. Gilbert, formerly with the United States Public Health Service, sent ORAL HYGIENE this unusual photograph made by one of his co-workers of a dentist in Dehra Dun, India, fitting a Gurkha soldier with a stock denture. This city, population 116,000, lies approximately one hundred miles north of New Delhi.—*Photograph by George M. Norris, Tallahassee, Florida.*

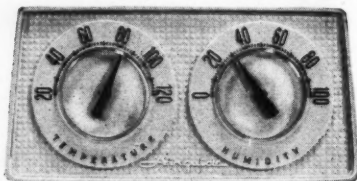


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Keep You Out of Tax Trouble

BY ALLAN J. PARKER, LLB, LLM*

ALONG about this time of year a number of dentists begin to complain—"I don't mind paying my taxes, but all these forms and books and accounts! Am I a DDS or a CPA?"

The short answer to that is that you are a DDS—a professional man engaged in an important health service. But, in another way, you are also a self-employed business man. In common with every other self-employed business man, the tax laws require you to keep minimum records that clearly reflect your income. A little thought, of course, makes it clear that without adequate records kept by everybody there would be no effective way of checking on the payment

Separating business and personal expenses is one safeguard against errors in reporting your income tax.

of taxes, and in the long run we would wind up with a highly unsatisfactory system of government supported by voluntary contributions.

Second, and perhaps more important, your records are your primary protection against running afoul of the tax laws, because those tax laws have penalties! During the calendar year 1956, for example, 1,509 individual taxpayers received prison sentences totalling 2,824 years, including suspended and probationary sentences. For willful evasion of taxes, the Internal Revenue Code provides a penalty of up to five years in jail or

*Mr. Parker is a member of the New York Bar.

\$10,000 fine, or both. Although gamblers draw the headlines, actually the bulk of tax offenders are otherwise respectable business and professional men—including a few physicians and dentists.

In addition to the criminal penalties, the law also provides a civil penalty of 50 per cent of any underpayment of tax where any part of the underpayment can be traced to fraud. This penalty is most often invoked where the government feels that there has been tax evasion but that the case is not sufficiently flagrant to warrant fine or imprisonment.

The key word in any tax fraud case is "willful." It means that the defendant knows or has good reason to know that his tax return is materially wrong. For example, in one case a defendant kept two sets of books: one which he furnished to the Revenue Agents showed a net income of, say, \$10,000; another which he called his "sho-nuf" books, showing \$25,000 income, he concealed. He went to jail.

Carelessness Not Fraud

Mere carelessness, however, is not fraud. The worst that can happen in a case of negligence in preparing your tax return is the imposition of a 5 per cent negligence penalty on any tax underpayment due to carelessness.

But where is the line drawn between carelessness and fraud? It is sometimes a thin line and that is where your records come in.

Take the case of Doctor Brown, the only dentist in a growing mill town in the South. He worked day and night helping patients. He received many of his fees in crumpled bills which he stuffed into his pocket. He meant to put this cash down in the book, perhaps, but frequently he would spend it for groceries or gasoline before a record was made. Because he was unable to find and train a competent bookkeeper, his records soon were in a sorry state as to how much money he actually received.

When it came time to make up his tax return, Doctor Brown had to rely on an overburdened memory. He simply put down as income the large fees, or those paid by check, of which he had made a record, and did not remember all of the small fees he had tucked away. Office expenditures, which were paid by check, however, were almost all there. As a result Doctor Brown was under-reporting his income by thousands of dollars each year.

After a few years the Internal Revenue Service checked up on Doctor Brown.

The Internal Revenue Agent soon concluded that something was seriously wrong and called in a Special Agent. Special Agents of the Internal Revenue Service, who are primarily concerned with criminal tax cases, have a number of weapons at their command to uncover hidden income. For example, they may even interview pa-

ORAL HYGIENE

tients themselves to find what they paid in fees.

Their most important weapon, however, is undoubtedly the so-called "net worth" method of prosecution. This simply means that the agents ascertain how much Doctor Brown was worth at the beginning of the period they are investigating—say, 1956. They then look at his assets as of, say, 1959, the end of the period in question. Let us say that during that time he had not bought any stocks, bonds, or real estate, but he had paid off a \$20,000 mortgage on his home and had invested \$10,000 in a new office and equipment. All the while, Doctor Brown had reported only \$12,000 per year net income. The agent concluded, after checking to see there were no inheritances or gifts received, that either Doctor Brown and his family had lived on only \$2000 during each of these three years (highly improbable considering that he paid about \$2000 in income taxes alone) or he had under-reported his income. A check of the places where Doctor Brown spends money, such as the grocery store, can fill in this gap. Result: the dentist had better call a good lawyer, for he will have a lot of explaining to do if he is to avoid penalties, fines, and perhaps even prison. It is hard to convince the agent that Doctor Brown has been merely careless where the errors are large, extend over a period of years, and always are to his benefit.

March 1959

Keep Records

Of course, this could not happen to you, you say. Probably not, but your best defense against its happening is to *keep records*; timely, complete records of all receipts, bank deposits and expenditures. Keep separate professional and personal bank accounts—maybe even in different banks. At the end of each day, transcribe the amounts received on your regular cards, or whatever other records you keep, and deposit receipts in the bank. Pay deductible expenditures, contributions, and taxes, by check.

Where you have a large and doubtful item of income or deductions, consult with a competent tax advisor—an attorney or a certified public accountant, and follow his recommendations. Reliance on a competent advisor is generally a complete defense to a fraud charge. If you give your attorney or accountant all of the facts and he advises you that you may deduct a given item, you and he may later be proved to be wrong, but you will not go to jail.

Voluntary Disclosure

Finally, even if a return with errors that might be said to go beyond mere carelessness and cross the borderline into fraud has been filed, there is still the possibility of avoiding criminal prosecution by going to the Internal Revenue Service and telling them about it before they check on you. Such voluntary disclosure was once a

complete defense to a fraud case. Now it is only one favorable circumstance in favor of the taxpayer. So if you should be in this position, by all means consult with your attorney before you do anything about your taxes.

Yes, the tax laws are tough. They have to be to keep noncom-

plying taxpayers in line for the benefit of us all. But if you keep simple complete records of the money you take in and what you spend for professional purposes you will stay out of serious trouble.

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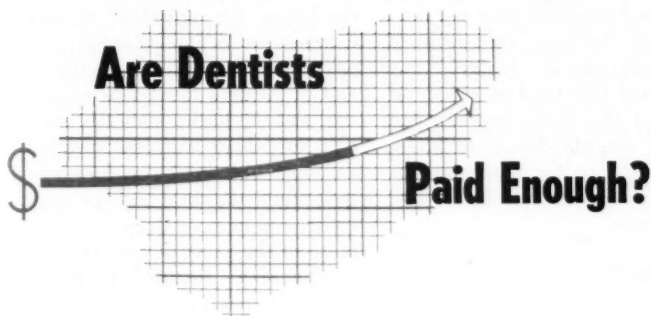
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Therapeutic Agents in Dentistry, The New York State Dental Journal, Lancaster, Pennsylvania.

THE COVER

THIS VIEW of Las Vegas at night represents an invitation to the Nevada State Dental Convention, which will be held May 10 through 12, at the Tropicana Hotel, Las Vegas. Requests for information and reservations should be addressed to Doctor O. M. Seifert, 755 Ryland Avenue, Reno, Nevada.



BY CHARLES P. FITZ-PATRICK

THE DENTAL profession is in a healthy condition in regard to fees. This is the opinion of an eastern economist who is aware that all dentists are not completely satisfied with their incomes. But, this economist points out, while the average dentist may rate the value of his services higher than his current fees, he remains wisely conscious of the dangers of pricing his profession above the financial reach of prospective patients.

One of the more favorable benefits of today's fee scale is the fact that fees are rarely the subject for derogatory living room conversations or profession-harming newspaper editorials. Also, it is not the fees that keep such a high percentage of patients out of dental offices; it is ignorance of the need for good oral health.

Laymen reveal some informative facts in voicing their opinions on the subject of dentists' fees for professional services.

When a half dozen secretaries working in the office of a shipping company were asked if dentists are paid enough they made no attempt at deep analysis. Four of them, however, quickly stated that they consider their dentists' charges fair. One of the group had no definite opinion. But the sixth, an older woman scheduled for early retirement, expressed a complaint that was also mentioned by other men and women. "During the years I could look forward to a regular income my expenses for dental care were not too great a financial problem. Now," she added, "as I am about to go on a pension I learn that I will shortly need a

partial denture. This will cost as much as I formerly paid my dentist for several years' care, and will cut deeply into my budget." She recognized this need as a natural result of the aging process, but since it was her dentist to whom she would pay the money he was on the receiving end of her mild displeasure.

A Solution?

A machinist, who is still employed but who has passed the peak of his earning capacity, offered his idea of a possible solution to this problem. He was recently told that he would need a full upper denture in the near future. "I had no idea this work was so expensive," he explained. "If I had been told some years ago about the cost I might have conditioned myself mentally." He suggested that others may fortify themselves against the financial blow by some sort of a "lay away" plan.

Although about an even number of men and women were asked if they thought dentists are paid enough, more men than women hinted that practitioners might be entitled to a slight increase in their income. The mothers of young children were the strongest objectors to any step up in fees. With extremely questionable logic one young mother said that since a child's teeth are smaller the dentist uses less material when restoring them. Another mother of a pre-school youngster referred to un-

related services and products to emphasize her objection to any increase in dental charges. She pays less in restaurants, on trains, and in theatres for her 5-year-old son, and the barber cuts the boy's hair for about half that charged an adult. She was unimpressed by the claim that a child could be more trying and in some cases consumes more of the practitioner's time. A mother of a "Dennis," while not anxious to pay more for the dental care given her boy, nevertheless admitted, "It takes both courage and patience to operate a drill in that boy's mouth."

Comparisons

When expressing themselves on the subject, men invariably made comparisons. A junior executive in matching a dentist's services against that of other professions pointed out the costliness of dental equipment, the variety of instruments, materials, and supplies the dentist must have. "These cost money," the young man recognized, "and someone must pay for them."

The reasoning that went along with this man's understanding of dental fees also prompted him to believe that dentists should emphasize the secondary benefits of their operations. A ten or even a fifty dollar dental fee would seem less to the patient who was made aware that the dental correction involved made him more acceptable socially, helped him create a

better impression on superiors in his shop or office, or aided in smoothing out worry lines that dental disfigurement can etch on a person's face. The logic of such an approach is comparable to the explanations being offered by pharmaceutical advertising. These messages point out that high price "miracle" drugs are really low in cost since they shorten the period of illness and put the patient back to work more quickly.

Point of View

When an apartment house manager and his wife were asked if they thought dentists are paid enough they mentioned a neighboring dentist and insisted, "He lives, vacations, and drives around in better style than most of his patients so he must be making plenty. A car dealer who sells one of the 'low price three' and a make in the \$4500 class said, 'My dentist customers don't go for the luxury models. They take the equipped lower price models, and most of them finance their purchases.' This was his way of saying that the dentists among his customers apparently were not being paid too much. And the advertising manager of a metal stamping firm answered the "enough" question in this manner. "Once a dentist builds up a practice he can depend on repeat calls for his services if he continues to keep his fees in line with his patients' incomes."

Adjusting to Income

When an engineer who works on large construction jobs was asked for his comments he gave an interesting explanation of how he selects a dentist. His work requires that he move from one construction project to another and stay for periods of six months to a year or more. When he needs dental attention he inquires around or asks a dentist directly, "What is the average income of your patients?"

This procedure is prompted by the engineer's belief that most dentists adjust the level of their fees to the average income of their prospective patients. "I know what I can afford," he said, "so I pick a dentist who can afford me." The engineer has been the patient of about ten dentists within the last dozen years and thinks that dental fees could be moved up slightly, but only by those dentists whose equipment and office surroundings indicate they are "on top." "While I have never walked into a dentist's office with my wallet wide open, I have walked out of several offices of 'cheap' dentists. If dentists will excuse the comparison," the engineer said, "it has been my experience that you can usually determine the worth of a man by the equipment he uses and the way he maintains it."

Education

During the interviews it became evident that many dentists must

refer frequently to the extent of their schooling when explaining their fees. This produces some reactions practitioners may not anticipate. Among patients who have had a minimum of formal education there is the feeling that the dentist is talking down to them. Others who have earned a degree, or who have put in an equivalent number of hours at specialized study, are inclined to compare their earning with that of the dentist. Of course, these persons use the highest figures they have heard or read about dentists' incomes. Too often these mental calculations give the dentist a higher than factual income. "My hourly rate is not half that earned by my dentist," a young electronic worker claimed, "yet I'm still going to school at night just to keep up with the new developments being made in my field." To this patient dental practitioners are being paid enough, but he arrived at this conclusion by comparing the cost of his education with that of the dentist.

The opinions that have been included in this report are all from more or less regular dental patients. That is, they are recalled by their dentists every six or eight months, or arrange for dental care at intervals not greater than a year or eighteen months. Most have in-

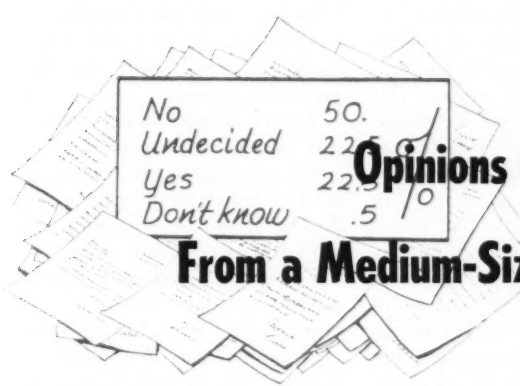
comes from \$3500 to \$10,000 a year. The average would be between \$5000 and \$6000. Three fall into the \$12,500 to \$15,000 bracket; and two, a husband and wife team who operate a successful resort restaurant and bar, probably net \$35,000 a season. Socially they are what might be termed middle to upper middle class, with fair to excellent educational backgrounds. In short, they are typical of the patients seen in urban and suburban dental offices.

Reaction to Increase

Most of those interviewed clearly revealed a strong human characteristic. They thought the other fellow was living in clover. However, there was little indication of jealousy. That is, most thought the dentist earned his money. Several men and women remarked, "A dentist works hard. He's on his feet constantly. He must keep patients calm even though they may be uncomfortable while in the chair."

Since this study revealed no violent objection to existing fees for average dental services, it appears that a slight increase in the dental fee scale would provoke little resistance among patients.

*3841 Aspen Street
Philadelphia 4, Pennsylvania*



No	50.
Undecided	22.5
Yes	22.5
Don't know	.5

Opinions on Fees From a Medium-Sized City

BY HAROLD S. JONES, DDS

IF YOU want to discuss an economic phase of our profession in a general way, then it is only proper to start with the problem at its source. We will then consider the number of breadearners and their income in our city of 106,000 population, with a hundred dentists listed in the telephone book, ten of whom are specialists. Here is a proportion of population to dentists that makes for keen competition.

About one-third of our population, or approximately 35,000, are below the age of nineteen, and here lies a vast amount of dentistry dependent on the breadearners. With 70,000 of the population remaining, it is a general average that about half of them are working, or 35,000.

Most of these dentists want to raise their fees, and they expressed the desire that the whole profession give dental service that is worthy of the cost.

Not many of us like to read about statistics, so my next statement will be the last one I will mention. Let us divide 106,000 by 35,000, and we get approximately three. Each breadearner must then pay for his dentistry and that of two others. Now, divide these breadearners into three or more classifications as to income, not forgetting that the largest number will earn the least, and then we only begin to approach the supply and demand of the dollar.

This point of economics, or the

ability of certain patients to pay more or less for their dentistry, is mentioned at this time in defense of the minority group in our profession, and I will explain this later. I have not as yet mentioned whether this pay is enough, and that is the question at hand.

In answering the question, "Are dentists paid enough?" I refuse to assume full responsibility, because I hope to live peacefully with the other ninety-nine dentists in my community. I telephoned approximately every other one of my colleagues as listed in the telephone book and asked them, "Are dentists paid enough?" I also asked the same question of a number of persons who are acquainted with our profession, such as salesmen, laboratory men, and other auxiliary branches, and I have recorded their remarks.

Degrees of Enthusiasm

I have before me a tabulation of all the answers, and I have arranged the names categorically according to the amount of enthusiasm they showed for their opinions on the subject. Their answer is an overwhelming negative one, that we are not paid enough; but the real truth is not as simple as that, upon further analysis of their remarks.

My categories are as follows:

First Group: 50 per cent, emphatically "No," with many reasons.

Second Group: 22.5 per cent, "Yes-No," with many reasons.

Third Group: 22.5 per cent, "I think we are," with the most amount of reasons.

Fourth Group: 5 per cent, "I don't know," with reasons.

Let me explain the reasoning I used to deduct the average of 7 to 2. The second group, with their yes-no answers, was interesting. They are the ultraconservative group, and they feel that their clientele are trained to expect their charges to be correct and fair, and therefore any increase in their fees would cause uneasiness. Each one, nevertheless, expressed the desire to receive a little more. These are then considered negative.

The fourth group was impatient about the question. They felt it was an individual matter, and that each man should get what he can for good service. These are also considered as negative.

The third group who answered, "I think we are" pleaded their case the hardest. This is the minority group, and it does not by any means include all the so-called low-priced men. These men were sincere in their opinions. They defended their position with, "Someone must take care of the low bracket income people. I'm getting all that I can and expect, and my patients come back and refer other patients." To my surprise these low-priced men stated, "I'm happy with conditions as they are."

We have several women dentists in our city who are married to dentists. Some of them are in active practice, others are not, but they are divided on the question. The women voted an emphatic "No," while their husbands' names were in the more conservative category. The nonprofessionals expressed a most emphatic negative, and had forceful reasons for their opinions.

Majority Want Increase

The vote then was actually 7 to 2, that our profession has lagged behind the times in regard to fees. Virtually everyone mentioned that other professions and tradesmen have advanced far above us. Their remarks invariably included that our basic education requires a great deal of time and expense, a dental practice is more expensive to establish, and our operating costs and living expenses are high. My colleagues gave me many examples of inequalities of the earning power of our profession in comparison to other professions. Their highest regards were given to the men of our profession who have upheld the fees, and they expressed a hope that every dental treatment would be worthy of its cost. In further discussions of the subject, many admitted they "don't know what to do about the price question." I could deduce from the

mass of information I received that they were pleading for the entire profession to do something.

Each man, I could sense, felt that a recent dental graduate should receive the same fees as a dentist who has been practicing for several years. They hoped that together, some way, possibly by patient education, individual improvement in technique, and by the integrity of our behavior and good dentistry, a concerted effort could be made to raise dental fees.

Public Lacks Appreciation

My colleagues told me that it was not only the competition with each other that concerned them, but the lack of appreciation by the public, and their poor judgment in evaluating dentistry. They said the amount of training that is necessary to have the precision needed to execute one restoration that often lasts a lifetime is a task well done, and we never get paid enough for that type of service. Operative dentistry was the bone of contention, and yet the better the dentist the more conscious he is of this fact.

These dentists were asking that you and I do what we can to be a credit to the profession.

*1121 Walnut Street
Allentown, Pennsylvania*

FEES:



The Experience of a Small-Town Dentist

BY HARRY C. PEAKE, DDS

Is **THE** dentist paid enough? Enough for what? To maintain a seagoing yacht and a fleet of cars? Then the answer is decidedly *no*! This question depends for its answer on the individual dentist and what he expects from life.

There is nothing morally wrong in a man demanding a large income with all the advantages it can provide—if he is willing to work for it. But there is something impractical when a man with these aspirations persists in practicing in a low-income area.

It is perfectly right for a dentist to have high-priced ambitions. It is just as right for the patient with a low income to feel that dental fees are too high—it all depends on the point of view.

When reduced to the least common factor, man's ambition is to produce a feeling of well-being within himself. This seems to be the starting point for reaching an answer to the question, "Are dentists paid enough?"

Speaking from a small town of about a thousand inhabitants, the answer might well be: "Yes, enough—but not *often* enough!" In communities where everyone is known by his first name, the control of credit and collections is more difficult than in larger centers. For the man who is content with small-town life, the fee scale is adequate. However, if he wants to practice in the small town, but "live it up" in the city, he might find his income insufficient. The man who wants money must go where the money is plentiful.

What you need to maintain a feeling of well-being should be the basis for determining the location of your practice and your fees.

A dentist from a large city visits in my town frequently. He drives a Cadillac. For a time he wanders around the lawns and gardens, sniffing the fresh air (no smog here). "Boy, you've got it good!" he exclaims. "What a place! You sure knew what you were doing when you left the rat race in the city. I'm going to find a small town and move there."

He enjoys eating the garden produce. "Just think," he tells his wife, "these lucky people can grow anything they want and get it so fresh the dew is still on it. This is for me. And fishing! If you want to go fishing you just hang a sign on the door. That's all there is to it."

He also appreciates a large house where he can go off to his room and read or sleep without being disturbed by what is going on elsewhere.

After a day or so of this kind of living he begins to smell the sulphur water that comes from the faucets; he notices where the house might be improved; he realizes his dental equipment is more up to date; he mentions (casually, of course) that his fees are much higher than in a small town; he

is amazed that certain foods he considers to be necessities cannot be purchased in the local food market—then he heads back to the city, glad to be on the road again.

In other words, this is a nice place to come to relax. But after doing so he is happy to get back into the "rat race" he pretends to despise.

Payments Other Than Cash

The point is, that whether a dentist is paid enough or not depends entirely on the individual dentist's mental attitude. What do *you* want? If the dentist carries through life a feeling of well-being, he is paid enough. If he is constantly reaching for a larger slice of monetary reward, he is *not* paid enough.

We usually get what we want—if we are willing to pay the price. I could more than double my income by going back to the city. That extra money would buy many things I would like to have, but it would not buy the gracious living of a small town. It would not buy the sweeping lawns and the blaze of color in the flower beds from the time the snow leaves until the frost kills them off in the fall. It would not buy the cardinals and bluejays coming back in the spring, or the flaming color of the maples which can be seen from every window in the autumn.

My answer to the question, "What do you want?" has been worked out. But that does not mean

for one moment that my answer is the correct one for somebody else. Each dentist must make his own decision according to his desires.

Remuneration does not always come in the form of a check or banknote. The case for which I received the highest fee in my experience did not net me one cent in actual currency. But it did gain me the friendship of a man which has stayed with me through ups and downs for over twenty years. Money is soon spent, but it cannot buy friendship or respect. When it is necessary to choose, which is the most valuable?

Which means the most—a five-dollar fee for removing a child's tooth, under tearful and terrified protest, hurrying and forcing the child to submit to treatment so that

production may be kept at a high level—or getting a confident smile from the child when it is all over, and the assurance that he will not be afraid to come back to *you* the next time?

To me, gaining the child's confidence is more important than the fee involved. Others may not see it this way. I may sound impractical. I do not say I am right, and the other fellow is wrong. I do say that for *me* it is right. By following this course of action I am making an adequate living and maintaining my feeling of well-being. So long as I can maintain this feeling, I am being paid enough.

*Timberlea
Parkhill, Ontario*

THE RESTLESS PATIENT

RARE INDEED is the urban American who can sit quietly alone without radio, television, smoking, chewing, or some form of entertainment or activity. We have become a people of noise, clamor, excitement, and motion, and often motion without sense of direction. A generation of this constant confusion and turmoil has left on us the imprint of restlessness, agitation, disquiet, tumult, alarm, and often panic. No one ever escapes the impact of this confusion and turmoil; no one ever will. It is our environment. From time immemorial man has sought by means of chemical agents to dodge the impact of his environment.

The zest for life is not in the goal but in the race, not in the achievement but in the effort. The race must go on and the effort remain unthwarted if a purposeful, tranquil existence is to be achieved. Saint Paul expressed it cogently in his first letter to the church at Thessalonica: "And that ye study to be quiet, and to do your own business and to work with your own hands." Labor of creation—painting, wood carving, weaving, and gardening—does much to tranquilize the restless patient.—*Current Medical Digest.*

The Dentist and His Income

in City Practice



BY HARRY CIMRING, DDS

DOES the dentist earn enough from dentistry? This question can be answered in several ways.

Stated simply, the average dentist with a metropolitan practice makes a good living. His family lives well; he entertains well; makes a good appearance; and his children are well educated.

There are, of course, some above average and some below average, as in all fields. The average varies from region to region within the United States, from state to state, from city to city within a state, and even from section to section within a metropolitan area. The average also varies between the specialist and the general practitioner, and between the various specialists.

These averages are further influenced by the fact that the dentist is either self-employed or salaried, in private practice or in governmental service, working full

The average city dentist is making a good living—and earning it, according to this California dentist.

time, part time, or semi-retired.

The chief factor affecting dental incomes in different parts of the country is the economic level and general prosperity of the area. However, another important influence is the availability and utilization of courses in dental economics and the activity of the professional bureaus, as in my state, in raising dental incomes. These latter factors have not only increased the earning power of dentists in all three categories (large cities, small cities, and rural areas), but have narrowed the differential among the three.

Within a metropolitan area itself, dental incomes may vary according to the economic level of the various sections (tempered by

the influence of the economics courses and professional bureaus I have mentioned). They may also vary between the so-called referral offices (within professional or office buildings) and the so-called neighborhood, or walk-in practices with the dentist's name visible to the passerby.

Available income figures show that the national mean net income of dentists increased 50 per cent from 1948 to 1952; 15 per cent from 1952 to 1955, and probably still more since then. The figures also show that, as a general rule, the small cities lead the larger cities, and both outdistance the rural areas in dental income levels.

Difficult Profession

Be that as it may, I feel a fairer and more equitable question is: "Does the dentist *earn* the money he gets for his dentistry?" This, too, can be answered in several ways, but, in general, the answer is a resounding: "Yes!"

First, dentistry is a highly skilled and exacting profession requiring much training and the assiduous and continuous application of knowledge and techniques, resulting in needed and gratifying services.

Second, despite the value of his services, his patients are, oral health education notwithstanding, reluctant individuals to one degree or another. The circumstances under which he functions are then often not the most congenial.

Third, the dentist knows where he will be every working day of his career—next to his dental chair. His existence has some of the confining qualities of a monastic cell. He cannot look forward, as a change of scene, to house calls and hospital visits as does the physician, to sessions in court as does the lawyer, to field trips as does the engineer.

Fourth, the dentist, perhaps more than most, is exceedingly dependent on his eyes, hands, back, and feet, all of which take a great deal of abuse in the performance of his profession. Unfortunately, he is blessed with but one set of these items.

Dentistry is a difficult, nerve-wracking, confining, and physically punishing profession, albeit not unbearable. As a general rule, the dentist certainly earns the money he makes from it. It behooves him to preserve the money he makes and the health required to continue practicing.

Though he is not as limited as an actor or a professional ball-player, for example, his earning ability has definite limitations. It is only fair that he and his live well, and that he is able to provide for the day when his eyes blur, his hands tremble, or his back gives out. Under those circumstances his career is at an end. Certain other professions may be continued, but not dentistry.

240 South La Cienega Boulevard
East Beverly Hills, California

ORAL HYGIENE



Practice Administration

Thought-Provokers

BY CHARLES L. LAPP, PhD, and JOHN W. BOWYER, DBA*

Timing as an Investment Problem

Emphasis is always placed on the proper selection of good investments. Buy good values and diversify and you will not have problems. The best investment can result in a loss if your timing is off, so an equally important question is, "When should I buy?"

There are three ways that the problem of "when to buy" can be handled. These timing methods may be used:

- *Analytical:* The investor forecasts the future course of business conditions, and attempts to predict the course of the stock market prices. This is usually not a practical method for a dentist, because it is too time consuming.
- *Mechanical:* There is a group of investors who ignore future business conditions, and concentrate on security prices and the patterns they follow. The idea is that all factors affecting security prices are reflected by the course of these prices, and they follow a definite pattern. A knowledge of the past patterns of security prices enables the investor to predict the future course of security prices.

*Doctor Lapp is Professor of Marketing; Doctor Bowyer is Associate Professor of Finance, Washington University, St. Louis.

- **Formula Planning:** Investing by a formula plan enables the investor to avoid for the most part the problems of timing. He invests periodically uniform dollar amounts without regard to the fluctuation of market prices. One of these plans and the most popular is Dollar Averaging. With this plan you ignore the present market at all times. You can over a period of time purchase your stock at a lower average price, than the average of the market prices during the period you use the plan. The reason for this is that the investor buys relatively more low-priced shares and relatively fewer high-priced shares. If you would like a copy of an example of this plan, write to PRACTICE ADMINISTRATION THOUGHT-PROVOKERS, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

Are You Doing Your Part to Avoid Letting the Unions Get a Stranglehold on Dentistry?

The threat of unions controlling a considerably greater portion of dentistry is imminent. Just ask the dentists on the West Coast and in the Northeastern part of the United States. One approach is to seek recognition of the importance of oral health by those in charge of the industrial hygiene programs. Industrial company executives should be encouraged by dentists to bring in a dentist on a part-time basis to diagnose: then the patient could go to the dentist of his own choice for treatment. Such a diagnostic program would cut down on the absenteeism of employees, and soon pay for the cost of the dentist's services.

Tips on Utilizing Your Dental Assistant

There are three basic areas with which you should concern yourself in managing your dental assistant.

- Selection: Hiring the right person (the biggest mistake you can make is to select a person who is only mediocre).
 - Training: Acquainting the right person with her duties. (A job description in written form should be the first step in training.)
 - Supervision: Being sure that the duties are performed in a satisfactory manner. (A check list may help you in managing your assistant.)
- Also, set up an appointed time to have a talk with each assistant.

Selection:

1. Be sure you have a person who is intelligent enough to absorb training, but not so intelligent that her job is not a challenge.
2. To assure that the person you hire has this intelligence and aptitude, use a professional testing service to administer at least a basic intelligence test. Intelligence tests and skill tests have a much higher degree of reliability and validity than personality tests.
3. Remember personality is as important as intelligence. Hire some-

one you can work with, because you spend on the average more of your waking hours with your assistant than you do with your wife and family. Personality can best be judged by interviews. Therefore, it is wise to interview a prospective assistant under a number of conditions. If you do not trust your own judgment or even if you do, it might be well to ask other colleagues to talk to a prospective assistant before making a choice. Then, too, if you have other assistants working for you, their judgment is important as to whether a prospective assistant will fit in with them.

Training:

1. Before hiring, make a written list of duties for your dental assistant. Be sure you know what you expect her to do.
2. Explain the relative importance of each duty. Few people can give a maximum effort to all phases of their job.
3. Insist on punctuality at all times. Stress in training the value of time to a dentist.

Supervision:

1. Insist on adherence to the work standards taught in training.
2. When standards are not adhered to, criticize; let your dental assistant know you are unhappy.
3. Do not mix criticism and praise. The criticism is often misunderstood and in many cases is not taken seriously.
4. Be explicit in criticizing and suggest remedial action.
5. Criticize poor performance, but be sure and reward special effort, such as superior work, or overtime duties.
6. Do not ever use "silent" criticism. It is nearly always misunderstood. The "silent treatment" criticism either causes exaggerated fears, or in many cases is not even recognized.
7. Re-examine work standards for dental assistants periodically and modify them when necessary. If you find that a dental assistant consistently does not meet your standards, dismiss her after a reasonable trial.

Study Psychology

If you will study the psychology of handling people you will no doubt find it will result in a more interesting challenge in your association with patients.

For example, if you detect that a patient is nervous, then be patient, considerate, and go ahead with what you are doing with extreme calmness.

If a patient is apprehensive, mention other patients (not by name) who have had a similar dental problem that turned out successfully.

If a patient is disagreeable, be pleasantly firm in your most convincing manner.

If a patient is silent, ask questions that cannot be answered by a "yes" or "no."

Remember, a patient "sizes you up," so estimate the patient's character and ability and the patient's opinion of you will always be better.

Courtesy Costs You Little

Courtesy to all patients and people you meet costs little, but you will be surprised what a practice builder it can be for you. It can work for you as well as it does for salesmen.

As an example, many years ago the salesmen in a large furniture store were standing around watching the rain fall one April morning when a shabbily dressed woman entered. All but one of the salesmen ignored her.

He was polite. He took her umbrella, and courteously asked her if he could be of assistance. He showed her various items of furniture, and answered all her questions. Then he showed her to the door, although he had not made a sale, and thanked her for coming into the store.

A month later the owner of the store called the salesman into his office. "Do you remember a rather shabbily dressed little old woman you waited on a month ago?" he asked.

"Oh, yes, on that rainy morning," the salesman replied.

"Do you know who she was?" asked the boss.

"I haven't the faintest idea," was the reply.

"How would you like a trip to Scotland?" the owner asked.

"Are you trying to kid me?"

"Not at all," said the boss. "That little old woman was Mrs. Andrew Carnegie, and you were so courteous to her that she wants you to go with her and Mr. Carnegie to Scotland to handle the outfitting of her new castle!"

Just try doing something a little extra nice each day for those you come in contact with and you will find your effort rewarded in many ways.

Words and Phrases Can Make a Difference

Such words and phrases as "please," "thank you," and "May I suggest?" probably cannot be overworked in your relationship with patients. "I" if you check, you will find is probably the most overused word in your vocabulary. The most discrediting word you can use is to refer to your dentistry as being "cheap." When making a case pre-

sentation you will find it useful to use the phrase, "When you have this dentistry completed," rather than, "If you have this dentistry completed."

You should not have to be warned to avoid slang or stronger words that lower your professional standing. Spice up your conversation with patients with action verbs and colorful adjectives.

Check With Those Who Have Invested

If you will check with those who have invested in closed end investment trusts on a regular and periodical consistency you will probably find they have realized more on their investment than those who have played the tips of others.

*Washington University
St. Louis, Missouri*

NOTICE

When you change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

FIRST MONEY FOR DENTAL EDUCATION HAS BEEN RAISED

MORE THAN \$75,000 has already been given to the Fund for Dental Education, although active solicitation is only now beginning. Most of the contributions to date have come from corporations, which are members of the American Dental Trade Association. That organization has made a direct grant and has encouraged its members to make Memorial Gifts to the Fund in tribute to departed colleagues and loved ones.

One of the first questions that is asked by foundations and companies approached for a gift is, "How well do your own people support your program?" or "What is dentistry doing to help dental education?" It is important that we start immediately to awaken members of the dental profession to the necessity for them to contribute regularly and substantially to the support of the schools of their choice, not only because their gifts will have a definite value but because these gifts will have the additional value of encouraging those outside the profession to realize that dental education is gaining support from the dentist and is worthy of substantial outside support.—MAYNARD K. HINE, DDS, *President, Fund for Dental Education, Indianapolis.*

March 1959

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So You Know Something About DENTISTRY!



By **ROLLAND C. BILLETER, DDS**

Quiz 174

1. A radiolucent periapical area may be (a) a dental granuloma, (b) an epithelial granuloma, (c) an incipient radicular cyst
2. True or false? Fitting the personality of the aged patient is often more difficult than fitting the denture to the mouth
3. What roots are closest to the floor of the maxillary sinus?
4. The causes of bruxism can be ascribed to (a) local, (b) systemic, (c) psychologic, (d) occupational, factors
5. Why is syncope dangerous in the diseased patient?
6. An unequal thickness of the porcelain crown (a) is, (b) is not, one of the factors most frequently causing fracture.
7. True or false? The main symptoms of mandibular overclosure and distal displacement are pains in the region of the joint, radiating into the temple, the ear, the pharynx, and the tongue
8. Why do acrylic resins fail to seal cavity walls?
9. When using rubber base impression materials an increase or decrease in the amount of activator paste apparently has (a) little, (b) considerable, effect on the setting time
10. What is the most important phase of root canal therapy?

FOR CORRECT ANSWERS SEE PAGES 80 and 82



The Alaska Native Service Hospital, Anchorage, where the Aborigines receive medical and dental treatment.—Photograph by Ward W. Wells, Anchorage.

Dentistry in Our Newest State— ALASKA

BY JAMES L. IRBY, DDS

This author, who is president of the Alaska Dental Society, presents specific information on dental facilities in Alaska.

ORGANIZED dentistry in Alaska dates from July 1950. Before that date a few dentists had met occasionally for reunion-type meetings, but this did not seem to meet the needs of dentistry. With these needs in mind, and with the desire to have a dental society that would be approved and recognized by the American Dental Association, Doctor Robert D. Livie, of Anchorage, began correlating information necessary to form an approved dental society.

An organizational meeting, to which all of the dentists in Alaska were invited, was held in Anchorage in July 1950, and the framework for a society was set up. Doctor Livie was elected chairman, and was later confirmed as the first president of the society. Doctor C. L. Polley, of Juneau, was designated secretary, and was later confirmed as first secretary-treasurer. The name "Alaska Dental Society" was selected, and the American Dental Association gave its approval of the organization. A charter was granted with a membership of twenty-five.

At present, the Alaska Dental Society has a total membership of forty-three, forty of whom are in private practice and three are employed by the Alaska Native Service. Since Anchorage is our largest city, it boasts the largest number of dentists. Fourteen of the Society members are in private practice in Anchorage. Fairbanks and Juneau each have five dentists; Ketchikan has four; Spenard, three; Sitka, Petersburg, Nome, Palmer, Seward, Haines, Kodiak, and Wrangall, one dentist each.

The yearly dues of the Alaska Dental Society are \$100. Alaska has an examining board composed of five dentists, and examinations are given annually beginning on July 6 through 10. Any applicant desiring to take the examination must pay a fee of \$25. The present secretary of the board is Doctor Richard H. Williams, Juneau,

Alaska. Applications should be made well in advance.

The 1959 annual meeting of the Alaska Dental Society will be held in Anchorage July 13 to 16. Convention Chairman is Doctor Frank Dorsey, 644 Seventh Avenue, Anchorage, who will be happy to answer inquiries concerning the meeting. For the benefit of the fishing sportsmen in our profession, I might add that, the season is open and fishing will be excellent in virgin lakes and streams.

Dental Laboratories

There are several dental laboratories in Alaska. Anchorage has four laboratories staffed with a total of seven technicians. Fairbanks, Juneau, and Ketchikan have one laboratory each, with one technician in each laboratory.

The Aborigines (Eskimos, Aleuts, and Indians) receive medical and dental treatment through a division of the United States Public Health Service, known as the Alaska Native Service. Dental and medical facilities are established in various areas in Alaska. The Alaska Native Service Dental Clinics' personnel have received numerous citations for proficiency in service and dedication to their profession.

Assistants' Training School

The Mount Edgecumbe Hospital and Training School, located across the channel from Sitka, is maintained for the Aborigines of Alaska.

ORAL HYGIENE

ka. The school is the equivalent of a high school, and also has a training school for dental assistants and dental technicians. The instructors and supervisors are dentists in the employ of Alaska Native Service. This auxiliary dental assistance school was established about 1949-1950, by Doctor R. M. MacKenzie, then the Director of the Dental Division, Alaska Native Service. Graduates of this school are capable chair-side and laboratory help.

Another dental facility operating in Alaska is the State Welfare Department. This service is available to the destitute for emergency dental treatment and rehabilitating oral treatment, with the prospect of returning the patient to an active physical condition whereby he can become self sufficient. This service is also available to the displaced native who finds himself in an area not serviced by the Alaska Native Service Dental Department.

In the vicinity of the greater populated areas, the Aborigines, and the destitute, have access to dental treatment, but people who live in remote areas sometimes travel hundreds of miles to obtain dental attention. Most of these people travel by air, as air travel service in Alaska is available by charter to even the remote areas.

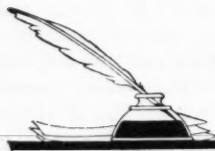
The population of Alaska is essentially young, and a young population has great working and earning capacities. However, the summer-time population is somewhat transient. There is no way to

"get rich quick" in Alaska, and when persons who come for that purpose find this out, they fail, and soon leave. *Alaska needs permanent residents who have a will to work, and to contribute to the growth and development of this new State.* There are a number of small towns that can be reached by automobile or railway (as well as by air), which need dental facilities. However, it is doubtful if one such town could support a dentist; but if the dentist were willing to establish himself to serve two or more such towns, he would probably find a satisfactory financial return and a real joy of accomplishment in service.

Life in Alaska can be a good life if one wishes to make it so. First, be sure that you want to live in Alaska, then have an understanding attitude. Bear in mind that this is a comparatively new country, which needs to be understood rather than criticized, and developed rather than pillaged. Alaska's resources are ripe for development. Because of their quality and quantity they are, and will continue to be, guarded jealously by our new State Government. Alaska will be developed in an orderly fashion for the benefit of capital, investors, and residents of this, our newest and probably to be, our wealthiest state.

To quote the poet, Sam Walter Foss, "Bring me men to match my mountains."

1010 Noble St., Fairbanks, Alaska



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

WHAT HAPPENS TO THE DISABLED DENTIST?

ANYONE who has seen a dentist who is permanently disabled is struck with the depth of the tragedy. A lawyer may be blind and still able to practice his profession. A physician may be partly paralyzed and continue to carry on a restricted practice. A business man may be incapacitated yet remain able to adjust to a work schedule. Not so with the dentist! The loss of a hand or an eye, partial crippling, means that his dental career has ended.

What can the disabled dentist do to support himself and family? It is unlikely that he can do anything in the *dental* field. Neither is he prepared to do much in *any* field. His training has been too highly specialized—or too narrow, if we prefer the blunter word.

A medical publication asked several physicians what they would do if they could no longer practice medicine because of disability. One said he would teach. Another believed that he could make a living running a nursery for shrubs and trees. A third said he would be a writer. Although these are admirable vocations, they are not comparable in economic terms to the practice of medicine. If a group of dentists were asked the same question, they would probably respond quite like the physicians.

What careers are open in the fields of teaching, horticulture, and writing, as examples of places of possible employment for the disabled dentist?

Teaching is itself a profession. Unless the dentist has something special to offer and some experience in teaching it is unlikely that any school would hire him, particularly if his health was impaired. Neither could he expect to find a position in a secondary school or a liberal arts

college as a science teacher unless he had, at least, a Master's degree.

Horticulture requires land, machinery, and money. Unless one has all three he cannot expect to make a living in any kind of farming. Estimates that have been made suggest that no agricultural undertaking can be made profitable unless a person makes an investment of no less than \$50,000. The small farm, the backyard poultry venture, the nursery with a few hundred plants and shrubs, cannot be made profitable. Any kind of farming is now big business.

Writing as a career may sound romantic. Actually it is drudgery. Not one free-lance writer in 1000 can expect to make a living in this career. There are well-paid positions in advertising agencies, on newspapers and magazines, but these jobs go to people with experience and special training and talent. Few novelists or free-lance writers have made a living from their efforts. Zane Grey, a dentist, was an exception. Arthur Conan Doyle, Somerset Maugham, A. J. Cronin, physicians, are other exceptions. But considering the thousands of people who grind out manuscripts every year that never see publication the successes of the few are striking. For the author who receives \$100,000 for motion picture rights to a book, there are thousands of writers who have never earned a penny. A writer is one who puts words on paper; an author has them published.

Although no human power can predict the future and thus foretell who is to be permanently disabled, every dentist can protect himself against such a misfortune by buying an adequate kind and amount of noncancellable insurance when he is young. Unfortunately many of these contracts terminate at age 60. The dentist who suffers disability after 50 now has some small protection under the Social Security system.

ORAL HYGIENE consistently publishes authoritative articles on investments, insurance, taxes, and other business subjects, because dentistry is both a profession and a way of making a livelihood. Beware of the self-righteous fraud who speaks to the contrary. No dentist who ignores the business side of dentistry is honest with his family, with society generally, or with himself.

Edward J. Ayman



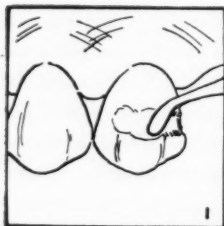
TECHNIQUE of the Month

Originated by W. EARLE CRAIG, DDS

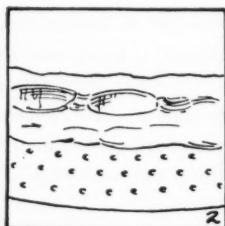
Crown for Clasp-Supporting Tooth

By G. J. GEIZER, DDS

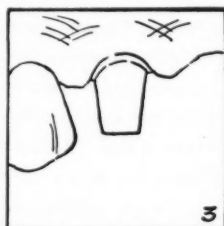
Drawings by Dorothy Sterling



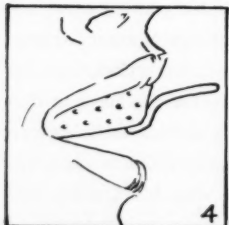
If tooth is carious, restore original contours with wax.



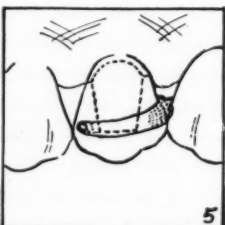
Take alginate impression and set aside. (Keep alginate moist.)



Prepare tooth in the usual manner.



Fill impression of tooth with self-curing acrylic. Position on preparation. Wait 5 minutes. Remove and trim acrylic crown.



Try crown and denture in mouth. Add wax to crown if necessary for support of denture clasp and rest. Invest and cast.

Note to Contributors

We invite dentists to submit material for this page. \$10. will be paid for each technique used. It is not necessary to make finished drawings—or even sketches—if you explain the procedure clearly, in detail, in your letter. Submit material to:

Technique of the Month,
Oral Hygiene,
1005 Liberty Avenue,
Pittsburgh, Pennsylvania

ORAL HYGIENE

Q

ASK Oral Hygiene

A

Please send all correspondence for this department to:

The Editor, Ask Oral Hygiene, 708 Church Street, Evanston, Illinois. Enclose a stamped, addressed envelope for a personal reply. If x-ray films are sent, they should be protected with cardboard. We cannot be responsible for casts or study models that are mailed to this department.

Periodontitis

Q.—I have a 21-year-old male patient whose gingivae bleed profusely at the touch of a toothbrush or an instrument. They are purplish-red in appearance, and are not ulcerated or hypertrophic. I have scaled the teeth and curetted the gingivae and treated them with Gentian violet. I have also prescribed vitamin C. Your suggestions and advice will be appreciated.—F.C.M., Pennsylvania

A.—Periodontitis, the most common periodontal disease of the adult, is a chronic, slowly progressive disease. In many instances it must, of necessity, have had its initiation approximately with the onset of puberty, or before, in order to cause the amount of destruction seen in the adult patient of 20 to 30 years of age.

Pocket reduction and elimination are one of the aims of conservative treatment. In attempting periodontal treatment, the following steps should be taken: the removal of such irritants as supragingival deposits, subgingival deposits, mechanical, chemical and atmospheric irritants, destructive habits and food impaction; and institution of proper home care methods; the correction and fortification of nutrition; and the polishing of exposed tooth surfaces.

Since you mention purplish gums, I would like to make a special point of improper instrumentation that is common and therefore leads to unsatisfactory results. Contact of the instrument with the most occlusal portion of the subgingival deposit is most often interpreted as contact with the base of the pocket, and the strokes of the scaler or curet proceed from this point occlusally. The subgingival deposit, however, remains to produce its damage to the periodontal structures. Once the instrument is apical to the deposit, the operator, with proper strokes, can expect to eliminate the calculus.

Dry Sockets

After reading an inquiry regarding dry sockets, it occurred to me that my experience with them might prove helpful to others having this trouble.

I make routine use of terramycin dental cones in all sockets, and virtually all sockets are sutured. This has resulted in not one dry socket in over three years, and I extract about 80 to 100 teeth weekly.—L.A.S., California

A.—Thank you for the information dealing with your personal treatment of dry sockets. On the basis of the amount of extractions you perform over a period of three

years, your freedom from dry sockets is impressive.

Pain on Percussion

Q.—I have a man patient about fifty years of age, in excellent health, who complains of severe pain and soreness upon percussion of the upper second bicuspid, and the first and second molars. There are no dental caries, no alveolar trouble, no restorations, and no history of injury or sinus distress. The x-ray is negative, except for filling or obliteration of the pulp canals. Upon removal of the first molar and dissection, the pulp and canals were found to be solid throughout.

I would appreciate your advice.—A.P.W., North Carolina

A.—If I had roentgenograms and study models, I might arrive at a more effective analysis in this case. As it is, from your statement that pain is elicited on percussion, I would, offhand, rule out calcification of the pulps as a causative factor, in this 50-year-old patient. From the slim evidence given me, I would guess that traumatic occlusion and unequilibration of the force lines are probably the factors contributing to "pain-on-percussion."

Bleaching Teeth

Q.—I read your explanation of the use of Superoxol® for discolored teeth in ASK ORAL HYGIENE. Could you tell me where I might obtain this product? Also, I should like to know the technique of using Superoxol to bleach discolored teeth.—F.L.W., Alabama

A.—The technique for bleaching teeth that I have found successful is as follows: Isolate the tooth with a rubber dam. Remove all filling material from the crown of the

tooth and from the coronal third of the root canal. Be sure that the root canal filling is satisfactory so that there can be no penetration of the root filling by the bleaching agent.

Superoxol, which is a 30 per cent solution of hydrogen peroxide in water, is the bleaching agent I use. A cotton pellet is placed loosely in the pulp chamber and the empty portion of the root canal and is flooded with the Superoxol. The cotton should be loose, acting as a wick to hold the fluid in the cavity. Then heat is applied, either with an old instrument that has been heated to redness or heat from the hot air syringe, being careful not to have the air dislodge the bleaching solution. Several applications of Superoxol and heat are made, and usually after 15 to 20 minutes the tooth has lightened considerably.

If the tooth is not bleached to the desired shade, Superoxol may be sealed in the pulp chamber for a day or two. Be sure that the coronal seal of cement is tight. After the tooth has been bleached to the desired shade the cavity can be lined with a silicone fluid, which helps to seal the dentinal tubules in case the restoration placed in the crown should leak. Many of the bleaching failures, I believe, are due to leaky seals of the coronal cavities. If the discoloration is metallic, due to the type of restoration that had been placed in the tooth, bleaching is difficult; if the

discoloration is due to the decomposition of organic material, particularly blood, bleaching is usually successful.

Superoxol can be obtained from your dental supply dealer or pharmacist.

Dentures and Food Accumulation

Q.—Recently I made full upper and lower acrylic dentures for a woman in her early sixties. She had worn vulcanite dentures about twenty-five years without difficulty. However, during the last two or three years food adhered to the sides of the dentures and accumulated.

In making the new dentures I opened her bite about 3 or 4 mm, and made the sides of the dentures thin, smooth, and highly polished. But the food still clings, making eating difficult. Please advise me how to overcome this annoyance.—J.O.H., Missouri

A.—It is possible that the change in the vertical dimension is responsible for your patient's difficulty with food accumulation. Until such a time as the patient becomes accustomed to plastic dentures, there is a tendency for some foods to adhere to the denture base material.

Fluoride Lozenges

Q.—What is your opinion as to the use of oral calcium fluoride (2 mg) lozenges in combination with vitamins C and D? Are they safe to use, and do you think there is benefit to be derived? Should they be restricted to any age group?

There is an immeasurable amount of fluorides present in our community water supply. I have received inquiries about ways in which to use fluorides as a preventive for individual children whose parents wish to do everything possible to

prevent dental caries.—W.R.W., Wisconsin

A.—Tablets containing fluorides in the form of calcium fluoride or bone meal have been classified unacceptable by the Council on Dental Therapeutics, because it appears difficult or impossible to provide an accurately controlled level of "effective" fluoride for the patient through the administration of these slowly soluble fluoride products.

According to the study made by the Council, there is not as much benefit through conscientious use of prescribed fluoride as through residence in a community where a fluoridation program is in operation. Certain potential hazards not associated with a community fluoridation program may attend the individual use of fluoride supplements. It is the opinion of the Council that the following principles should be observed in the use of dietary supplements of fluorides:

1. Concentrated fluoride preparations should be dispensed only on prescription in order that adequate supervision may be provided for their safe and effective use.

2. Supplementary fluorides should be prescribed only when the concentration of fluoride ion in the drinking water is known and is less than 0.7 part per million.

3. Dietary fluoride should be continuously available throughout the period of tooth formation.

4. No more than 264 mg of
(Continued on page 60)

sodium fluoride should be dispensed at one time.

5. Concentrated fluoride preparations should bear the warning statement: "CAUTION: Store out of reach of children."

6. Prescriptions should be limited to those instances where the parent may be expected to follow directions carefully.

Flouride tablets may be employed with least difficulty in localities where the drinking water is substantially devoid of fluoride. Written directions should be provided according to the age of the child as follows:

1. Before two years of age. Add one fluoride tablet to each quart of water used for drinking pur-

poses and for the preparation of formulas and other food.

2. From two to three years of age. *Every other day* add one fluoride tablet to an amount of fruit juice or drinking water which the child will consume at one time.

3. After three years of age. Administer one tablet *each* day in an amount of fruit juice or drinking water that will be consumed at one time.

I hope the foregoing information will be of some help to you.

Denture Relining

Q.—Please send me a laboratory procedure to reline a denture after an impression has been taken in it.—P.L.K., New Jersey

(Continued on page 62)

NEW! oxilane silicone paste . . . accurate impressions . . . easily obtained



easy to use utilitarian package



Pleasant tasting, odorless, Oxilane is the ideal rubber impression medium. Sets in 2 minutes. It's free of chemical action after set and has ideal dimensional stability. Stone models can be poured up at any time. Can also be copper or silver plated. Exclusive wetting agent lets Oxilane go beyond moisture barriers, under gingival tissue to cavity wall. Look for the Lang trade name . . . your assurance of the finest materials made.

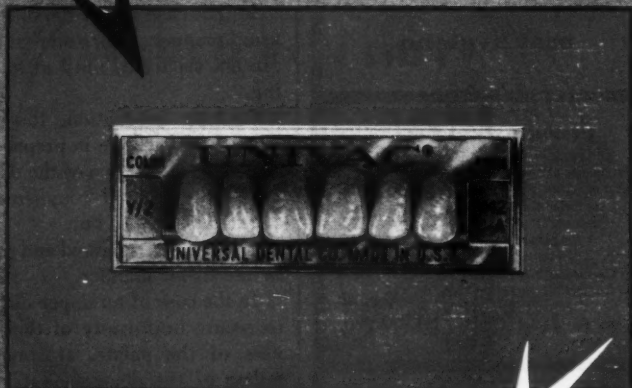
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MOLDS HAVE BEEN ADDED TO PROVIDE THE MOST COM-
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important to thorough
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Lavoris for the prevention and local relief of inflammatory conditions of the mouth and throat. It is a properly formulated mouthwash-gargle that accomplishes thorough cleansing and stimulation of tissues.



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cleansing action of Lavoris is unique. It coagulates and removes sticky, mucoid deposits from tissues. These non-adherent deposits are then easily washed away.

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LAVORIS
is a stable solution of zinc chloride and recognized adjuncts. It's pleasant tasting, yet contains no sugar.

SUGGEST regular use of Lavoris to your patients.
It's a pleasant, rewarding habit.

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gallon of Lavoris is available to practicing dentists and physicians. Please order on your professional stationery, including \$2.50 for each gallon (delivery prepaid in the continental U.S.A.).



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A.—Following are the steps for relining a denture:

1. The impression is boxed and poured in Hydrocal®.
2. The case is now flaked in the usual manner. Impression and cast are not separated until after flaking.
3. After separation, the tissue side of the denture is prepared by the removal of some of the denture base material and roughening of the surface with a bur.
4. The case is flaked and packed in the usual manner.

In the case of an upper denture; to secure uniformity of the thickness of the palate, at times the palate of the denture is removed and rewaxed prior to flaking.

Odor in Edentulous Mouth

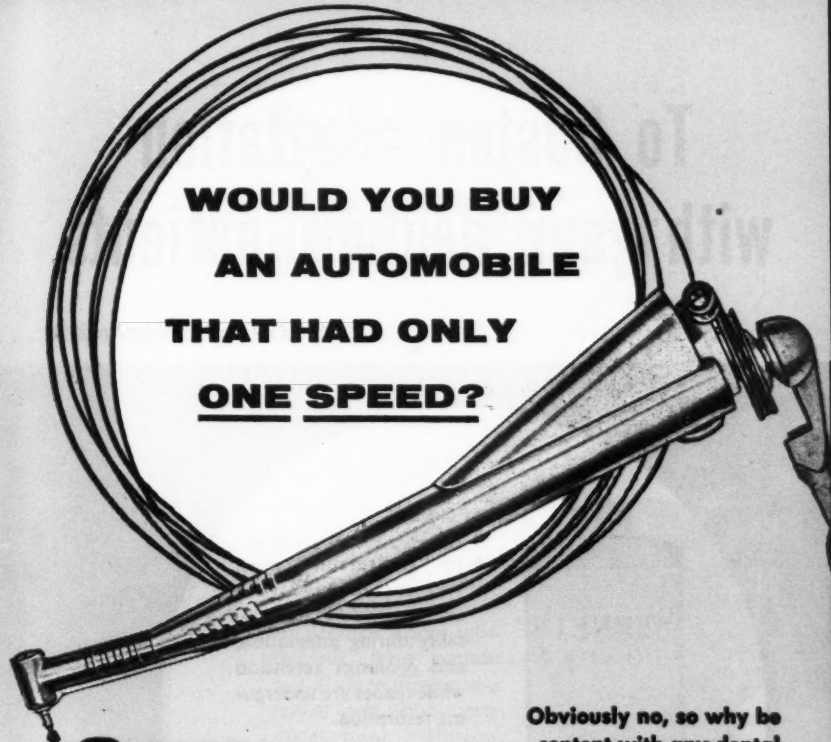
Q.—In September 1952, I constructed an upper and lower immediate denture for a woman about forty years of age. In May 1954, I rebased the lower with a quick mouth-curing plastic. Nothing was done to the original upper. The rebase material of the lower is hard and nicely fused to the lower denture.

In October 1958, the patient came to my office and complained of a foul, obnoxious odor that is supposed to originate from the dentures. This odor is not steady or constant, but comes and goes. Some days it is not there, and others it persists only for a few hours. On the day of examination I could not detect any odor.

The patient has a nervous temperament, but the physician claims there is nothing systemically wrong with the digestive organs. The gingival tissue appears normal. The centric and fit seem satisfactory. The dentures are clean. The tonsils have been removed.

I have explained to the patient that plastic dentures are nonporous, and therefore cannot absorb moisture or food secretion.

(Continued on page 66)



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THAT HAD ONLY
ONE SPEED?**

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To hasten adaptation with your denture patients

..... This product helped



- In "treatment" cases, Wernet's Powder provides added comfort and stability during adaptation, and prolongs retention while tissues are undergoing resorption.
- In all cases where anatomical or psychological problems occur, Wernet's helps the patient through the adjustment period.

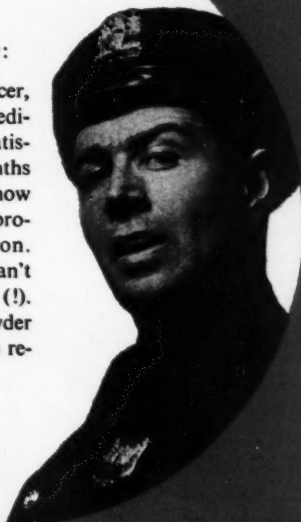
● Wernet's Powder helps speed the mastery of the denture . . .
Recommended by more dentists than any other denture adhesive.



Recommend WERNET'S Powder

..... *this patient*

- A typical case history:
- JBL, city police officer, 48 years old. Had immediate dentures placed satisfactorily three months ago. Gum resorption now makes them wobble, produces some irritation. Biggest complaint: can't blow police whistle (!). Using Wernet's Powder until it is practical to re-line dentures.



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this dentist was ... A MIGHTY HUNTER

... until experience convinced him that STEELE'S® offered the finest, most versatile products for all types of Bridge-work. Interchangeability, the outstanding feature among many advantages, is original and superior with Steele's.

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***STEELE'S SIDE GROOVE POSTERIOBS**—for greater strength in cast removables; available in popular Bioform® shades.

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THE COLUMBUS DENTAL MANUFACTURING CO.
Columbus 6, Ohio

The patient wants an answer. Can you help me?—C.J.P., Wisconsin

A.—The problem of mouth odor, especially in an edentulous mouth, should be readily handled. To begin with, one has to determine whether it is primary (arising from the denture, the nasal or paranasal sinuses, the pharyngeal anatomy, or a nonessential localized desquamative mucositis). If the local factors do not contribute to the mouth odor, then one has to look for the secondary factors. The latter are further subdivided into physiologic and pathognomic.

Physiologically, many foods, after being digested and absorbed and then filtered through the liver, still give off their characteristic odor for many hours after ingestion. The odor is not due to a backing up of the gastric content; but rather the result of the odor coming from a substance (usually a nitrogen-sulfur organic derivative) which does not lose its odor as a result of digestion or assimilation, and is carried through the blood stream to the tissues and eventually is washed out of the tissues through the kidneys, fecal excreta, and the secretory glands. Garlic and onions, for example, may leave an aftertaste for hours after ingestion because of this phenomenon, and this is normal, or physiologic.

On the other hand, any putrefactive disease process of the alimentary canal, especially gallbladder disease, colitis, or even a gastric ulcer, can give off putrefactive derivatives which are odoriferous and are absorbed into the liver where they are "detoxified." The latter process frequently does not

imply deodorize, as the odors again are carried into the blood stream and are given off through the salivary glands as a mouth odor. It is felt that the agent which gives off such lasting odor may also be a putrefactive derivative containing a nitrogen-sulfur grouping.

From what you state in your symptomatic picture, it is my impression that this patient's problem is one of a dietary nature and is physiologic.

Fractured Central

Q.—In July 1958, a 9½-year-old boy presented with an upper right central which had been fractured through the crown of the tooth. There was slight mobility of the tooth, but little edema and hemorrhage. A stainless steel crown was formed and placed on the tooth by use of zinc oxide and eugenol cement after the fractured area, which was near the pulp, had been coated with calcium hydroxide. The tooth was then splinted.

The boy was re-examined on September 15, 1958. The tooth responds to vitality tests and is quite firm and there is no discoloration. There is some translucency around the mesial part of the apex which I cannot diagnose as either the beginning of a granuloma, or merely bone that was destroyed by trauma.

The boy's mother is anxious to have some restoration made for cosmetic purposes, although my advice is to retain the stainless steel crown for at least another six months. What is your advice on this matter?—N.H.M., New York

A.—The fact that two months after fracture the tooth still retains its vitality, is firm, and shows no discoloration, is encouraging. Evidently, the pulp is still vital despite any injury it may have suffered. The prognosis for full recovery and continued vitality is good. If tooth vitality was deter-

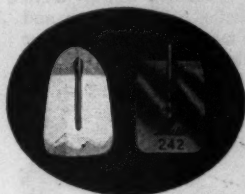
(Continued on page 68)

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Also—the widely used Steele's P. G. and H. H. Backings for Facings; Steele's Super-Cast Backings for Trupontics and Steele's Volatile Backings for High Burnout Chrome Alloy Cases guarantee the interchangeability of Steele's Teeth.

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mined by the electric pulp test, thermal tests should be used as a check test.

In view of the foregoing clinical findings, it is highly probable that the narrow zone of radiolucency on the mesial aspect of the root end is without significance. Bone architecture and x-ray angulation can sometimes be responsible for what appear to be suspicious areas.

It is recommended that protection of the tooth by the steel crown be continued for about a year. This should permit the pulp to recede and to insulate itself against external injury by secondary dentine. Periodic re-testing of the tooth, especially prior to any permanent restoration, is of course indicated.

Nausea Caused by Denture

Q.—I have a patient who has a lower denture and he cannot keep it in his mouth because it nauseates him and he must take it out. Kindly advise what to do.—J.F.D., Illinois

A.—Without more detailed information it is difficult to make a diagnosis and solution to your problem.

In my own experience, I have found that nausea generally presented itself as a problem with the delivery of an upper denture; however, since the mandible is in intimate relationship with the maxilla and neighboring tissues, it would seem possible to develop a nausea sensation in the delivery of a lower denture. I would carefully examine the lingual flanges for possible overextension. I would check the thickness of material covering the tuberosity. In extreme cases of

(Continued on page 70)

when impaired
oral health reflects
a deficiency in

water-soluble vitamins...

Good oral health requires an adequate daily supply of the water-soluble vitamins B and C:

"The relationship between malnutrition and gingivitis seems evident....The predominant deficiency was in the vitamin B complex."¹

In herpangina, "all six cases responded quickly to therapeutic B complex (Allbee with C), with complete disappearance of the lesions within a week. To date none of these lesions have recurred."²

1. Sud, V.: J. D. Res. 30:19, 1951.

2. Nathanson, I. G. and Marin, G. E.: Oral Surg., Oral Med. and Oral Path. 6:1284, 1953.

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Formula:

Each capsule of Allbee with C contains:

Thiamine hydrochloride	15 mg.
Riboflavin	10 mg.
Calcium pantothenate	10 mg.
Nicotinamide	50 mg.
Ascorbic acid	250 mg.

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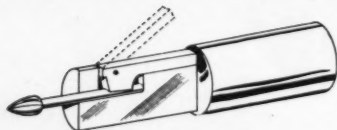
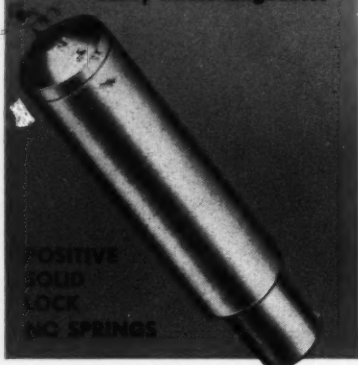
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over-closed bites there have been impingements of this material which could simulate the feeling of nausea.

The patient might be suffering an anxiety factor which subconsciously relates to his teeth. If this is the case, two tablets a day (morning and evening) of meprobamate (Equanil® or Miltown®) 400 mg are prescribed. As a rule, medication may be discontinued in 10 days to two weeks as the patient should be adjusted to his dentures by that time.

Self-Polishing Amalgam

Q.—Several weeks ago I placed an amalgam restoration for a woman patient. I gave her an appointment to return in about a week to have the restoration polished. Upon her return, to my amazement, I found that the restoration had a brilliant polish. In fact, every amalgam restoration in her mouth had the same luster. She said that to her knowledge they had never been polished.

Do you know of any explanation for this self-polishing phenomenon?—J.S.C., Arizona

A.—Your description of the patient who returned with polished amalgams is most interesting. Discussions with many dental colleagues does not help to unravel the mystery. Some suggest that the patient may use a hard toothbrush effectively on all surfaces of the teeth.

Painful Jaw

Q.—I am writing to you regarding an unusual case. The patient is my brother. Here is the general history of the trouble, as he has outlined it in a letter to me, which reads as follows:

"Upon awakening one morning my right jaw was swollen and sore at the joint, about one inch from the ear; also, my jaw cracked noticeably, and it was

hard to open my mouth wide. I wrote to you about it, and at your suggestion I bathed it with hot salt-water packs, but there was no appreciable benefit.

"I then went to an osteopath for about ten treatments, but there were no beneficial results, except to ease the pain at the time of treatment. I then went to the physician you suggested, who in turn sent me to an x-ray specialist. The specialist said it was an arthritic condition of my right mandible, and the physician recommended the use of hot-water packs, as you had suggested, but there was no relief. I had my teeth x-rayed also, and the dentist said they were normal. I have all my teeth (at age 72), and few restorations. To date, after more than six months my jaw is no better. I hope you can find out what I can do about it, as my jaw bothers me a great deal."

I have never seen a persistent case such as this before, and I do not know what to suggest. There surely must be some sort of treatment that might relieve this trouble which came on overnight. I will certainly appreciate any information or advice which you may offer.—C.B.B., Colorado

A.—When a case of this type is presented by letter or second-hand information it becomes difficult to evaluate and analyze on a sound cause and effect basis; however, I can give you my views as to the possible cause of your brother's condition.

From the description that your brother has presented, I believe he is suffering from an articular disc arthritis, a fibrochondritis of the head of the condyle, the interarticular disc and the articulating fossa of the temporal bone. This condition was most likely in the making for many years as a result of normal attritional wear of the occluding surfaces of the teeth; but because of the advanced age of the patient, the articular surfaces noted

(Continued on page 72)

March 1959

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DR. _____

STREET _____

CITY and STATE _____

above did not compensate as readily as might be expected. The acute flare-up which he experienced, was probably brought on by an ordinary harmless pressure such as sleeping on his fist. This may have induced a mild subluxation because of the existing inflammatory process, which became aggravated from the traumatic additive.

As an initial phase of treatment, based upon the foregoing analysis, an intraarticular injection or two of steroid to allay the inflammation would be indicated. In the meanwhile, the use of salicylates or salicylamides with massive doses of ascorbic acid and nicotinic acid should be given orally. A good combination of the latter in palpable and easy to take tablets is put up commercially as Vastran® by Wampole. As soon as the pain decreases and movements improve, a bite block system should be constructed to gradually open the bite on an intermittent basis. Once satisfactory opening without pain or muscle stretch is accomplished (it might take several weeks to three months to arrive at this desirable point) permanent onlays or onlays affixed to a partial denture may be constructed. It is important that during the restorative phase the patient be kept on the oral therapy. I might add that the best way to accomplish the treatment would be on a team basis. The team should be comprised of an internist, oral surgeon, and a dentist.

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Dentists in the NEWS

Dentist Heads AMA Auxiliary

A dentist is taking a year's leave of absence from her practice to aid the Nation's physicians. Doctor Gladys Underwood practices dentistry in Portland, Oregon, and lives with her physician-husband in nearby Vancouver, Washington. As the American Medical Association auxiliary head, Mrs. Underwood has been traveling throughout the United States, overseeing the auxiliary's program of service to physicians and communities. — *Minneapolis (Minnesota) Tribune*.

Collector of Degrees

New president of the Los Angeles County Dental Society, Doctor H. Chester Moore of Long Beach, a 1952 graduate of University of Southern California's School of Dentistry, also holds a degree in music from Baker University in Kansas and an engineering degree from Yale University. He plays in the dental society's Dixieland band, and in the German band. Other hobbies are golfing, fishing, yachting, short-wave radio operation, and growing of orchids and Camellias.—*Long Beach (California) Independent Press-Telegram*.

Builds School for Handicapped

Because they were unable to find any institution that could help their multiple handicapped daughter, Doctor and Mrs. Charles Jordan of Springfield, Illinois, founded the Hope School for Blind Multiple Handicapped Children. So far the school has been a "pilot project," a two-story frame building with four to six children and a staff of similar size. It has been financed by the \$20,000 the Jordans have put into it, and contribu-

tions from friends. But its success has so interested professional groups that its founders have ambitious plans for its future. The officers of the National Federation for the Blind invited Doctor Jordan to come to Boston to speak to them, because they are considering the school as a project. They have long wanted to start something of the kind, Doctor Jordan said, but thought it would take a minimum of \$500,000.

At present Doctor Jordan is negotiating with Springfield for a 10-acre tract of land near the lake for \$1-a-year rental. If this goes through he hopes to raise funds to proceed with his dream—a plan for six Y-shaped units, each unit to have 12 children and two resident house parents, so that they could serve 72 children at one time.—*St. Louis (Missouri) Post-Dispatch*.

Dentist Jazz Group

Five Detroit area dentists, Doctors Carroll Kennedy, John Pericin, Chester Bogan, John Rasmussen, and J. Wilfred Harrison who meet a couple of times a month to swing out with a Dixieland beat, were recently the subject of an article appearing in the magazine section of the *Detroit News*. Doctor Bogan, who is the arranger for the group, carved his own trumpet mouthpiece from brass, had it silverplated and inscribed with his name. They tape record many sessions.—*Detroit (Michigan) News*.

Win Naval Awards

Twenty-three Twin Cities dentists who make up Naval Reserve Dental Company 9-17 have received a Ninth Naval District general excellence trophy and first-place

(Continued on page 76)

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oral analgesic compound
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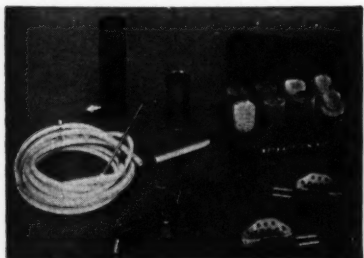
SUPPLIED: Distinctive, 2-layer yellow-and-green tablets, bottles of 48 (prescription required). Each tablet contains 75 mg. of ethoheptazine citrate and 325 mg. (5 grains) of acetylsalicylic acid.

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76

plaque. Commander of the unit is Captain William A. Dickson.—*St. Paul (Minnesota) Dispatch.*

Donates One Month's Services Yearly

Two years ago, in December 1956, Doctor and Mrs. John E. Shultz of Pella, Iowa, lost their only child, an adopted daughter of 14, in an automobile accident. In order to overcome their grief, they decided to do something for other children. Each year they spend the month of October (their daughter's birthday month) at Annville Institute, a church operated boarding school in Jackson County, Kentucky, giving dental service to the mountain children. Of the 170 students, 100 had never been to a dentist. During his first month at the institute, Doctor Shultz placed 358 restorations, and made 52 extractions. Mrs. Shultz served as his dental assistant.

Doctor and Mrs. Shultz are enthusiastic about their project, and have a great admiration for the Kentucky mountain folk they served. They also have a feeling of deep satisfaction over what they have accomplished.—*Des Moines (Iowa) Tribune.*

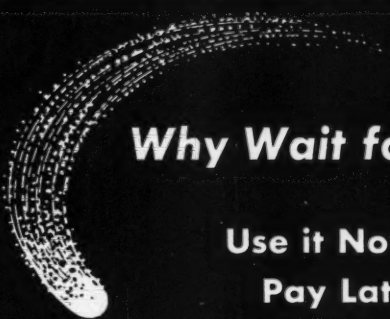
Alumni Funds Build School

Dedication ceremonies for a \$275,000 two-story addition to its School of Dentistry clinic building were recently held at the University of Southern California. Doctor J. Franklin Maley of Pasadena, president of the Century Club which donated a major share of the cost, presented Doctor Norman Topping, president of the university, with a key to the building. The Century Club is an organization of 375 alumni and friends of the dental school who annually give \$100 each to its support.—*Los Angeles (California) Examiner.*

Medal Collection Rated "Best"

Doctor Samuel N. Bruni, of Lewiston, New York, has one of the largest and finest collections of medals, decorations, and orders in the United States. He is a member of the Orders and Medals Society, numbering more than 700 numismatists. No mere armchair collector, Doctor Bruni was awarded the Silver

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and Bronze Stars for valor in combat in World War II and Korea. Thrice wounded, he is possessor of the Purple Heart with two bronze stars, as well as about a dozen campaign and service ribbons. Besides his United States decorations, the former Marine was honored by the South Korean government with the award of the Order of Chung Mi with Silver Star.

He has specimens of all but one medal or ribbon ever issued by the United States, from the original Purple Heart, instituted by George Washington during the Revolutionary War, to the Korean campaign. The lone medal needed to complete Doctor Bruni's collection is the Dewey Medal, issued during the Spanish American War to sailors who served under the famed admiral.—*Niagara Falls (New York) Gazette.*

Town Expresses Thanks

Nearly 100 friends and colleagues honored Doctor William C. Ralston at a testimonial dinner for his 57 years of

dental service to Milford, Connecticut. Now 84 years of age, Doctor Ralston's service to the people of Milford covers many areas. He was founder of the blood bank at Milford fifteen years ago. He also established the first dental clinic in the Milford schools, and served in it without pay. Age prevented him from serving in the Armed Forces during World War II. It did not prevent him, however, from helping those who were serving, and he let it be known that he would provide free dental service for anyone in the Service.—*New Haven (Connecticut) Register.*

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

Blanche Butler, 1230 West 8th Street, Los Angeles, California

Fred J. Meine, DDS, 1245 East Colfax, Denver 18, Colorado


Edwin Bircham, 1745 North Berendo Street, Hollywood 27, California


(Continued on page 80)

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Merle Ostrom, Route 3, Brainerd, Minnesota

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Bruce A. Bonsack, 683 Sherburne Avenue, St. Paul 4, Minnesota

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ 174

(See page 50 for questions)

1. (a), (b), (c). (Weiss, Gabriel: Cellulitis of the Face and Neck, DENTAL DIGEST 63:538 December 1957)
2. True. (Jamieson, C. H.: Geriatrics and the Denture Patient, J. Pros. Dent. 8:11 January 1958)
3. The first molar roots. (Archer, W. H.: A Manual of Oral Surgery, ed. 2, Philadelphia, W. B. Saunders Company, 1956, page 446)
4. (a), (b), (c), (d). (Nadler, S. C.: Bruxism, JADA 54:617 May 1957)
5. The compensatory mechanisms may not be able to operate. (Accepted Dental Remedies, 23rd Edition, American Dental Association, 1958, page 11)
(Continued on page 82)

DOCTOR...

Continuing Studies Confirm GARDOL'S* EFFECTIVENESS In Caries Control

RECORD TO DATE

Following Use of Colgate Dental Cream
containing Sodium N-Lauroyl Sarcosinate*

TRIALS**	AGE GROUP	GEOGRAPHICAL LOCATION	RESULTS - % REDUCTION IN NEW DF SURFACES	
			DURING 1ST YEAR	DURING 2ND YEAR
1	ADULTS	SOUTH	46%	38%
2	ADULTS	SOUTH	63%	66%
3	ADULTS	MIDWEST	54%	71%
4	ADULTS	MIDWEST	58%	0%
5	CHILDREN	WEST COAST	45%	43%

CONCLUSION: The results shown above support the view that the regular use of Colgate Dental Cream will materially assist your patients in their personal efforts to combat tooth decay.

Significantly, these results—based on several two-year clinical studies—were consistent and free of all adverse side effects. They involved both adults and children in a wide variety of geographical locations.

*Gardol is Colgate's Trade-Mark For Sodium N-Lauroyl Sarcosinate. This ingredient in Colgate Dental Cream is safe for children of all ages since it does not stain teeth or endanger developing tooth enamel.

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6. (a). (Saklad, M. J.: The Disclosure of Fracture Lines in Porcelain Restorations, J. Pros. Dent. 8:115 January 1958)
7. True. (Sicher, Harry: Oral Anatomy, St. Louis, The C. V. Mosby Company, 1949, page 476)
8. Excessive shrinkage. (Hirsch L. and Weinreb, M. M.: Marginal Fit of Acrylic Resins, JADA 56:13 January 1958)
9. (a). (Yurkstas, A. A. and Kapur, K. K.: Immediate Denture Impressions with Rubber Base Materials, DENTAL DIGEST 63:268 July 1957)
10. The proper filling of root canals. (Kuttler, Yuri: A Precision and Biologic Root Canal Filling Technic, JADA 56:38 January 1958)

SYSTEMIC DISEASES WITH ORAL MANIFESTATIONS

THERE ARE over two hundred systemic diseases which, at some point in their clinical course, show oral symptoms or signs. In some cases, the oral findings *precede* the clues elsewhere. This is classically illustrated by the Koplik's spots which precede, by twenty-four or more hours, the cutaneous eruption of measles. In other disorders, the oral findings *parallel* those in other areas. The enanthem of chickenpox falls into this category. Finally, there are situations where the oral changes *follow* the symptoms and signs in other parts. This sequence may occur, for example, in lupus erythematosus.—*Dental Clinics of North America*, W. B. Saunders Company.

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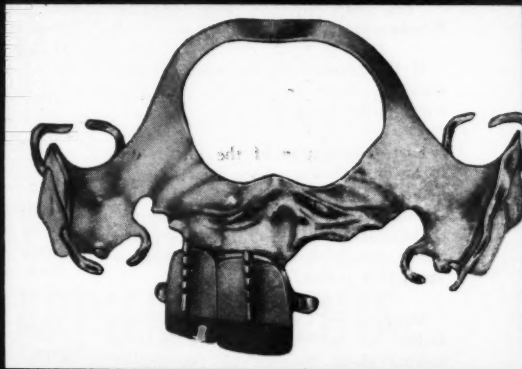
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LAFFODONTIA

"My wife suggested that I take up a new sport."

"What a sweet, thoughtful girl; did she suggest anything?"

"Yes. Say, by the way, what is Russian roulette?"

* * *

If the weather is the same in Hawaii the year around how do they start a conversation?

* * *

Kiss—contraction of the mouth due to an enlargement of the heart.

* * *

Judge. "How did the trouble start?"

Defendant: "Well, judge, she asked me to play a round and I didn't know she was a golfer."

* * *

Daughter—"Can't we ever teach father to say 'fertilizer' instead of talking about 'manure' all the time?"

Mother—"Better let well enough alone. Remember how long it took us to get him to say 'manure'?"

* * *

"Do you know that brother of yours is liable to get himself into trouble?"

"What has he been doing?"

"He's going around telling lies about me."

"As long as he lies, what do you care? But if he begins to tell the truth, break his jaw."

* * *

"What are the names of the bones in your hand?" the professor said to a student in his medical class.

"Dice," the student replied.

* * *

Prof: "What three words, Jones, are used most by college students?"

Jones: "I don't know."

Prof: "Correct."

Ed: "I guess you've been out with worse-looking fellows than me?"

No answer.

Ed: "I say, I guess you've been out with worse-looking fellows than me?"

Susie: "I heard you the first time. I was just trying to think."

* * *

The views expressed by husbands in their homes are not necessarily those of the management.

* * *

Mac — "Any girls write you when you advertised for a wife?"

Nick — "No but some men did."

Mac — "How come?"

Nick — "They wrote that I could have theirs."

* * *

Salty—"Gosh, you have a lovely figure."

Susie—"Oh, let's not go all over that again."

* * *

CAUTION—Be sure your brain is turning over smoothly before putting your mouth in gear.

* * *

First Frosh — "There's a woman peddler at the door."

Second Frosh — "Tell her we'll take two."

* * *

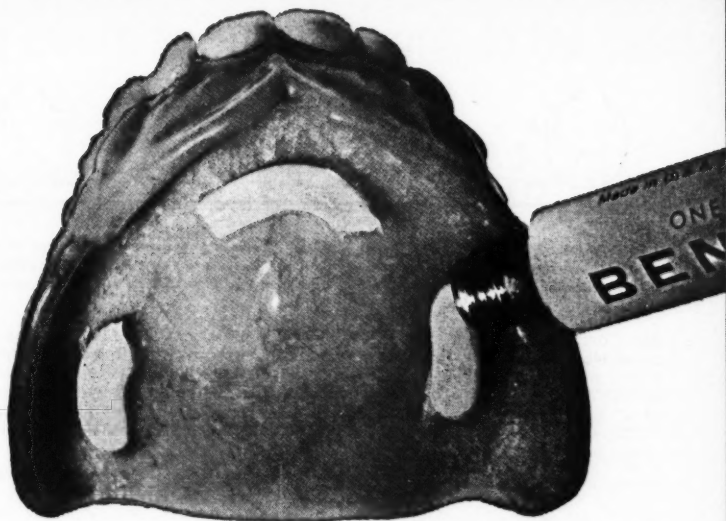
Farmer: "I sure miss the old cupid since it's gone."

Wife: "You always missed it, that's why it's gone."

* * *

She: "What are all those men doing in a circle with their heads together? Is it a football team?"

He: "No my dear, just a bunch of Scotchmen lighting a cigarette."



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WHAT'S NEW

IN PRODUCT DESIGN—
FUNCTION—ASSORTMENT



The purpose of this department is to provide a convenient, up-to-date source of new product information from data provided by manufacturers. You may obtain additional information by writing to them. Listing does not imply Oral Hygiene's endorsement.

Air Compressor—Capacity for two air-driven handpieces. Twin cylinder, 2 h.p. motor, delivers 4 cu. ft. min. ASME approved tank. 18" diameter, 24½" high. Weber Dental Manufacturing Co., Canton, Ohio.

Rest Curve Chair—The Ritter Euphorian is designed to comfortably "cradle" the patient and assure support to all parts of the body. "Rest-Curve" seat discourages patient slumping, keeps patient in best operating position. Embodies touch-of-the-toe elevation and tilt. Available in usual range of colors. Ritter Co., Inc., Rochester 3.

Flask Press—Rugged, inexpensive, easily-operated hydraulic press, making the mould-packing phase of the curing procedure a hand lever operation. May be attached permanently to a bench. Available in either one or two flask capacity. Hanau Engineering Co., Inc., Buffalo 9, N.Y.

Steel Plug Finishing Burs—For friction-grip handpieces. Effective for ultra speeds for grinding, polishing and finishing. Packed six (assorted) to a box. Premier Dental Products Co., Philadelphia 7.

Autoclave—Embodies a number of time and work-saving additions, including single knob control, automatic timer, a safety door that cannot be opened under pressure, a thermostat in discharge line and stainless steel construction. The Pelton & Crane Co., Charlotte, N.C.

Air Compressors—Model 420, replacing Model 314, displaces 4.2 cfm,

an increase of 33-1/3% in capacity. Adequate to operate two air driven handpieces simultaneously while supplying air for other requirements. An economy Model J also available. The Pelton & Crane Co., Charlotte, N.C.

Denture Base—Characterized Tru-Life with Ginga-Tint. Permits the utmost naturalness together with maximum strength and durability. Allows natural gum tints to blend with denture. Available in single-unit, moisture-proof foil pouches. The William Getz Corp., Chicago 19.

Explorers—The Morse Scaler Explorer Package contains 6 new stainless Explorer Instruments, 10 Scaler instruments and 4 chuck-type handles. Points are quickly interchangeable. The Ransom & Randolph Co., Toledo, Ohio.

Motor Chair M-1—Controls on either side raise or lower chair on telescoping slides with roller bearings. Tilts to horizontal position with effortless ease. Aluminum die castings are used extensively for strength and serviceability. Available in standard colors. The S. S. White Dental Manufacturing Co., Philadelphia 5.

Precision Locked Rest—Designed for specific use as a removable replacement of any fixed soldered joint in

bridgework or splinting of restorative units. Incorporates the principle of a mechanical friction lock plus the positive locking action of a set screw. Available in four models. Wilkinson Co., Box 303, Santa Monica, Calif.

Surgical Mallet (Reiter)—1959 model is operated and adjusted with one

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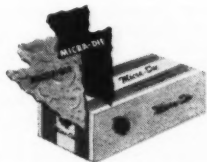
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hand. Frees left hand for sponging and retracting. Can be used routinely on any extraction. Union Broach Co., Inc., Elmhurst, L.I., N.Y.

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Endodontic Non-Pinch Plier—For use with gutta percha and silver points. Can also be used for all purposes of a cotton plier. Premier Dental Products Co., Philadelphia 7.

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X-Ray Units—New, electro-stabilized, including all basic General Electric features and safety advances. Added safety through filtration exceeds Bureau of Standards requirements. Improved electronic timer offers positive indexing and automatic reset. Available in models No. 90-II and 70-II. X-Ray Department, General Electric Co., Milwaukee 1.

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1. GALE, Dent. Rec. 71:15 and 71:184, 1951

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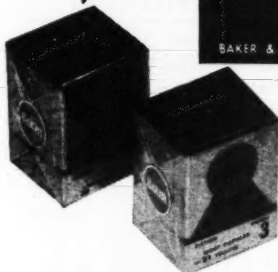
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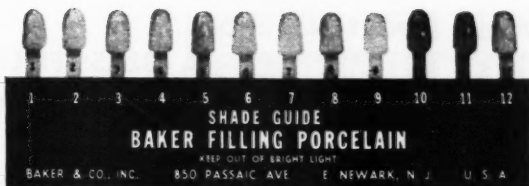
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Poly-Glas margins are impenetrable, no marginal leakage or staining. Same coefficient of expansion and contraction as a tooth.

ESTHETICS

Poly-Glas will match tooth structure more accurately than any other filling material. The index of refraction of glass fibers makes for perfect color harmony between filling and tooth.

SIMPLE TECHNIQUE

Poly-Glas can only be used with

the slab technique. Mix powder and liquid on slab same as old silicates. Wet cavity walls and floor with Poly-Glas liquid. Insert entire mix in cavity. Metal or resin matrices may be used. Allow to set for five minutes. Trim excess with carborundum discs, polish with sandpaper disk using cocoa butter as lubricant.

RECOMMENDATIONS

Use in any class cavity.

Use conventional cavity preparation.

In deep seated cavities use insulating base, preferably a calcium hydroxide preparation.

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A high lustre toothlike filling that is almost impossible to detect. And it stays that way. No discoloration, no marginal stains, no washing out, no wearing down, no chipping. And unlike the tooth that has just been filled, Poly-Glas lasts and lasts.

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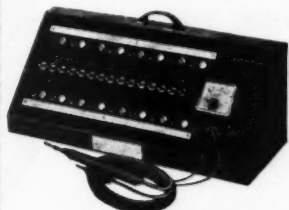
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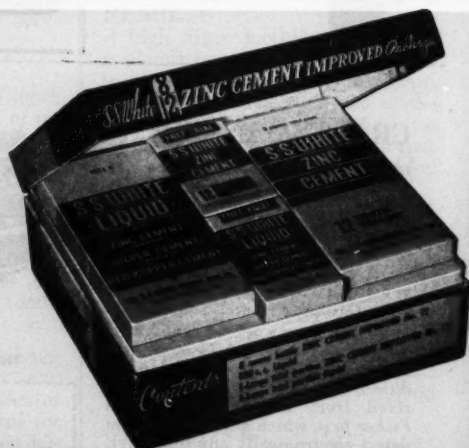


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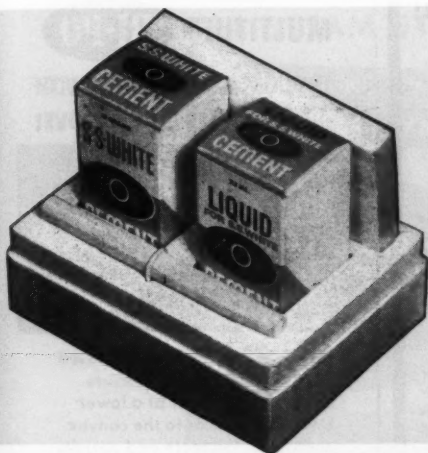
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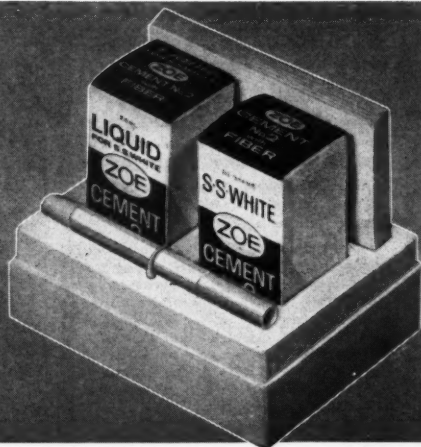
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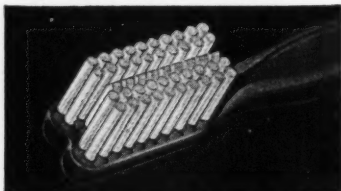
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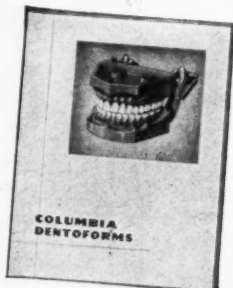
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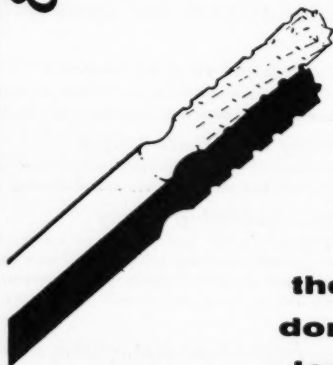


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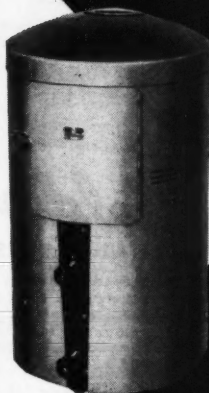
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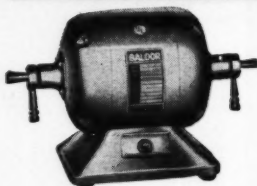
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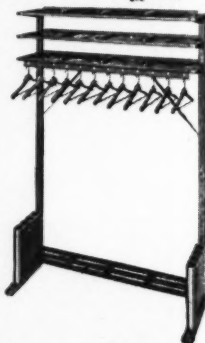
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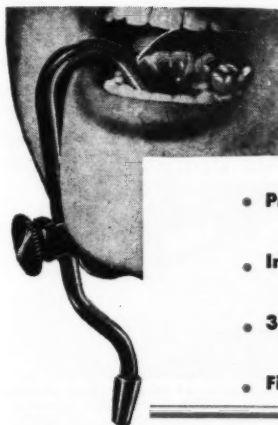
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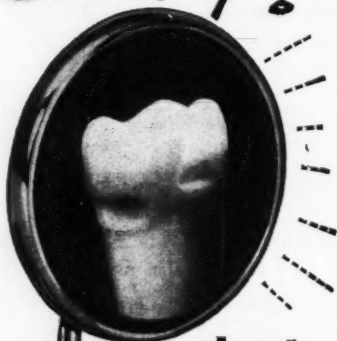
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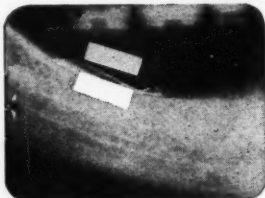
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	2	20	20	50
	3	25	25	55
	4	30	30	60
	—	35	35	65
	5	40	40	70
	—	45	45	75
	6	50	50	80
	—	55	55	85
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	10	90	90	120
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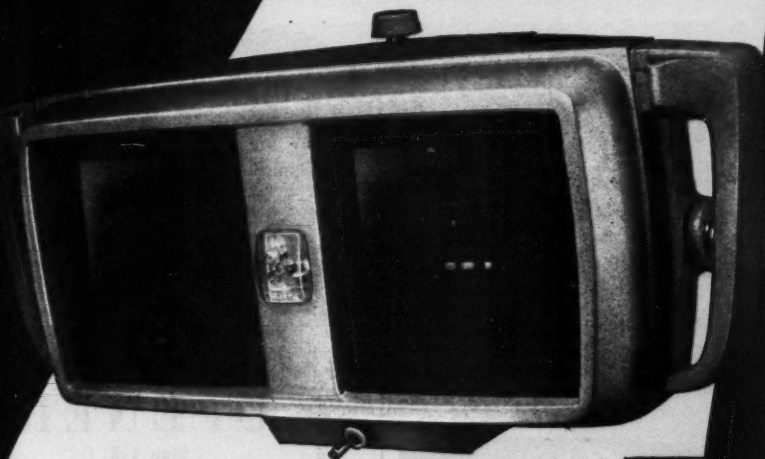


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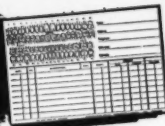
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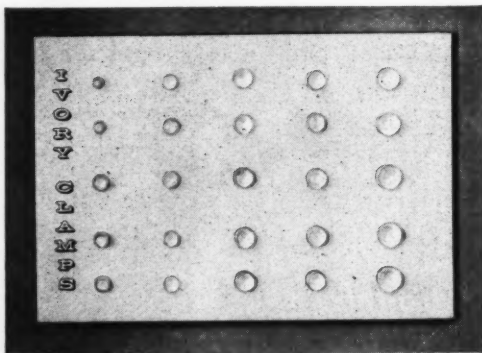


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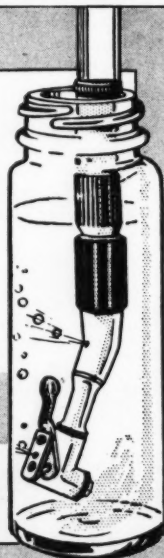
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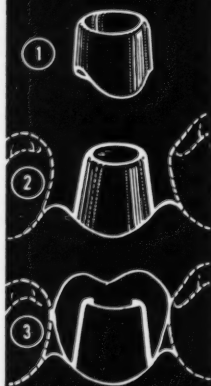
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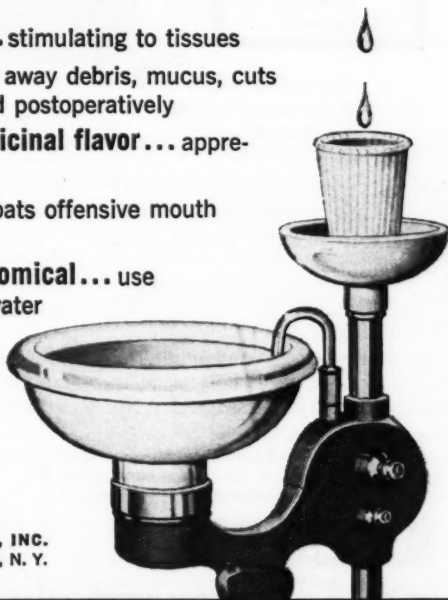
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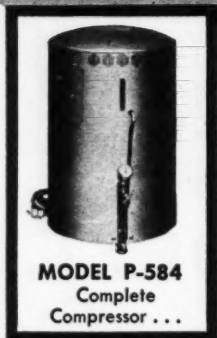
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now...
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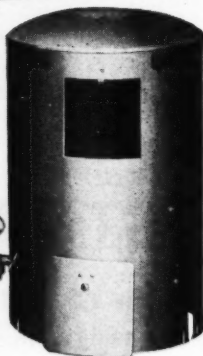


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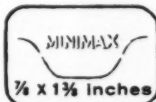
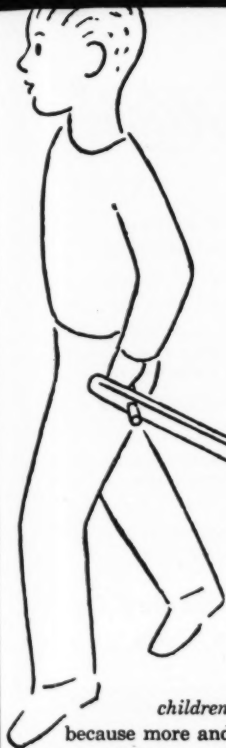
*Available whenever customers need such pressures for certain handpieces, etc.



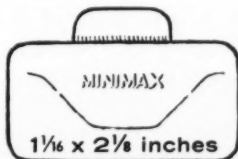
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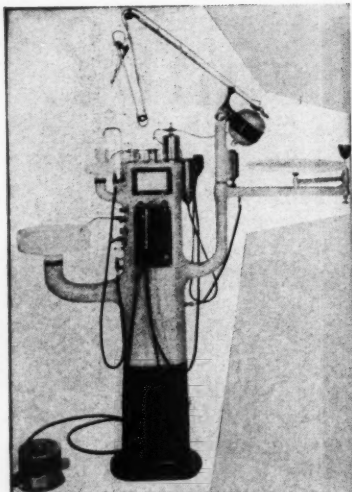


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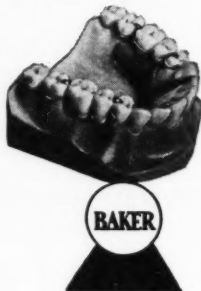
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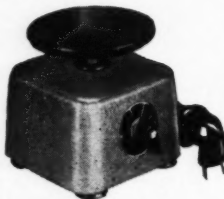
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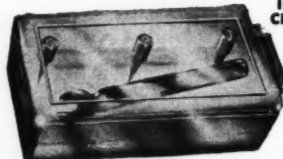
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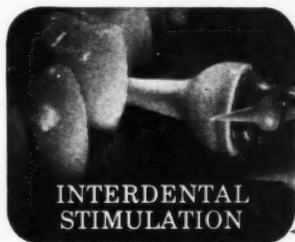
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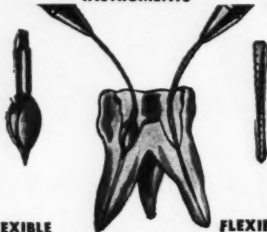


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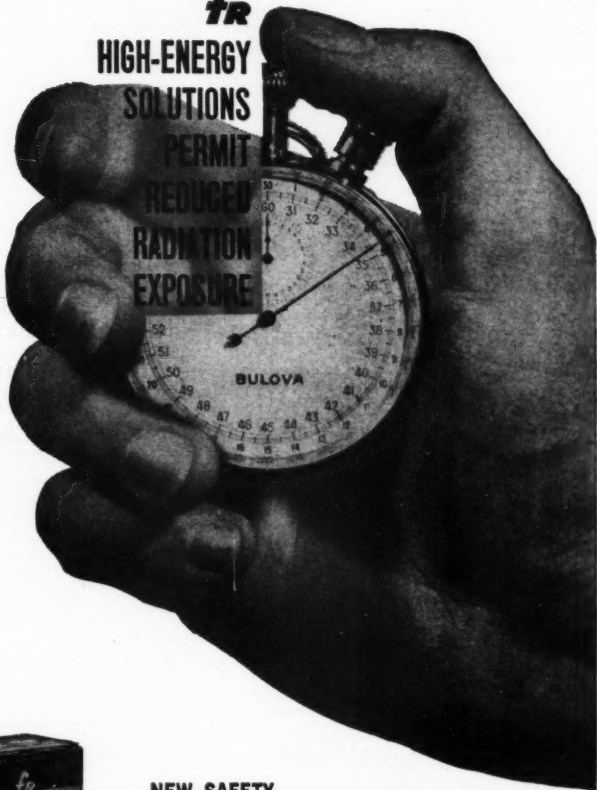
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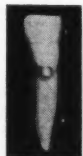
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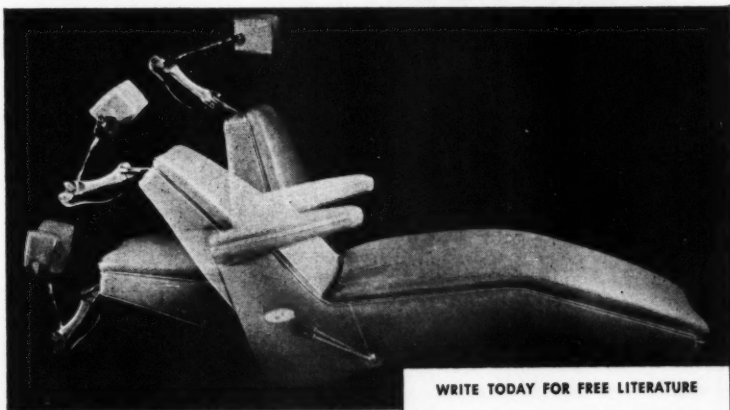
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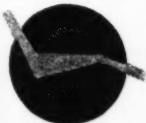
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The occlusal rest



FIG. A



FIG. B

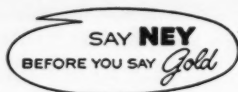


FIG. C

Occlusal rests supply a substantial portion of the support required for the clasp type of partial denture. They must resist the heavy masticatory load and yet maintain the correct clasp-to-tooth relationship. Sometimes no rest seat is prepared in the abutment tooth, leaving only room enough for a thin rest which soon breaks (Fig. A).

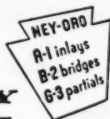
The rest preparation in the abutment tooth should be definite but not box-shaped as in Fig. B. A sharp angle at the marginal ridge produces a corresponding angle in the casting that may cause fracture.

The ideal rest preparation (Fig. C) is spoon-shaped with its floor at right angles to the long axis of the tooth. Bucco-lingually its width is about one-half the distance between the buccal and lingual line angles of the surface involved. Sharp angles are smoothed and the prepared enamel surface is carefully polished.



(Prepared under the direction of competent dental authority.)

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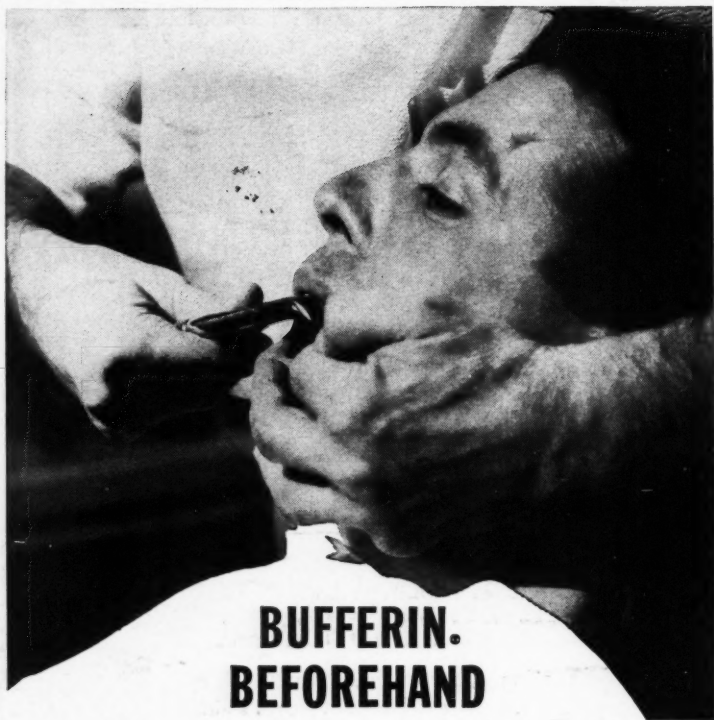
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